THE MAUDSLEY HANDBOOK OF PRACTICAL PSYCHIATRY

FIFTH EDITION

EDITED BY
David Goldberg
Robin Murray

OXFORD

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The Maudsley Handbook of Practical Psychiatry

Fifth edition

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Preface to the fifth edition

We have reviewed the entire text and brought it up to date throughout. Since publishing the last edition, this book has been translated into Italian, Japanese, Russian, and Spanish. We are delighted that a book written for trainees in England has been found useful in other countries, and aware of a heavy burden upon us to keep the book up to date. As we go to press, the Mental Health Act has yet to be revised; therefore we have continued to describe the present law, but have written a short section on likely future changes.

Once more, we have leaned heavily on others as consultant advisers, and relied upon our trainees to tell us what they want to see in a handbook to be carried in their pockets or handbags. The trainees who assisted us previously were Drs Elvira Bramon, Matt Broome, Lucy Cameron, Steve Church, Elaine Healy, Clare Henderson, Tennyson Lee, Paul Moran, Marco Picchioni, Rob Stewart, Nigel Tunstall, Elizabeth Walsh, and Harvey Wickham.

While many of the changes to the new edition are fairly minor, we have largely rewritten the sections on the social state, assessments of personality, and cross-cultural assessments, and revised the text on 'Things you need to know about' to include the probable alterations to the Mental Health Act in the United Kingdom. Many modifications have been made to our chapter on 'Early treatments', as there are many changes that need to be included.

We are indebted to many colleagues who have assisted us in making these amendments, in particular Professors Dinesh Bhugra and Mathew Hotopf, as well as Drs Jonathon Bindman, Paola Dazzan, Khalida Ismail, James Maccabe, Paul Moran, Veronica O'Keane, Colin O'Gara, Carmine Pariante, Maxine Patel, Lawrence Reed, Stephen Scott, Ulrike Schmidt, Rob Stewart, George Szmukler, and Ann Ward. As before, responsibility for the final text rests entirely with ourselves as editors.

David Goldberg
Robin Murray

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List of abbreviations

AMT	Abbreviated Mental Test
ASW	approved social worker
AUDIT	Alcohol Use Disorders Idenification Test
BMI	body mass index
CBT	cognitive–behavioural therapy
CJD	Creutzfeldt–Jakob disease
CNS	central nervous system
CPA	care programme approach
CPN	community psychiatric nurse
CSA	childhood sexual abuse
CSF	cerebrospinal fluid
CT	computed tomography
CVA	cerebrovascular accident
DHSS	Department of Health and Social Security (UK)
DSH	deliberate self-harm
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (4th edn)
ECT	electroconvulsive therapy
EEG	electroencephalography
EPSE	extrapyramidal side effects
GP	general practitioner
ICD10	International Classification of Diseases, 10th Revision
IM	intramuscular
IQ	intelligence quotient
IV	intravenous
MAOI	monoamine oxidase inhibitor
ME	myalgic encephalomyelitis
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
MMSE	Mini-Mental State Examination
MND	motor neuron disease
MRI	magnetic resonance imaging
MS	multiple sclerosis
NHS	National Health Service (UK)
NICE	National Institute for Health and Clinical Excellence
NMS	neuroleptic malignant syndrome
OCP	obsessive–compulsive phenomena
PD	Parkinson's disease

PTA	post-traumatic amnesia
SLE	systemic lupus erythametosus
RLAI	risperidone long-acting injection
RMO	responsible medical officer
SSRI	selective serotonin reuptake inhibitor
TCA	tricyclic antidepressant
WHO	World Health Organization

Chapter 1

The psychiatric interview with adults

Interviews on the wards or in the outpatient department with adult patients *2*
Interviews on emergency duty *9*
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This chapter separates the kinds of interview techniques that are usual when making a full assessment of a patient (this page) from those required while on emergency duty (p.9). There are special considerations when interviewing elderly patients (p.12) or those with learning dis ability (p.15).

Interviews on the wards or in the outpatient department with adult patients

The psychiatric interview has many features in common with the medical interview, namely that its two main goals are to elicit the necessary information to make a diagnosis and to try to understand the aetiology of the disorder for that particular individual (the 'formulation'). Again, as in medicine, most of the information required for a diagnosis in psychiatry comes from the history rather than the examination or any investigations. However, there is a third feature of the psychiatric assessment which, although important in medicine, is more explicit in psychiatry, i.e. using the interview as a means of obtaining a therapeutic trusting relationship with the patient. This is particularly important when the patient may not feel that s/he has a problem either because of a psychotic illness or where s/he has considerable ambivalence about his/her desire for help with his/her problems, such as eating disorders or substance abuse. This approach whereby reviewing a patient's problems against the backdrop of offers of psychiatric help has been formalized as compliance therapy and motivational enhancement therapy. Lastly, the psychiatric interview can also have value as a psychotherapeutic intervention.

Recording information elicited from the interview

Notes are best written at the time of the interview, remembering to name and date each sheet and to give the time of the interview on the first sheet, since it is rare that the busy clinician will have time to write up notes after meetings. Some doctors find it helpful to record information under different headings on several sheets at once; this is particularly useful when recording verbatim examples of speech for the mental state. Prior to the interview one should review any referral letters and any past medical notes, and clarify any confusion or request any further information.

Outside the interview room

After introducing yourself, explain who you are and why you wish to see the patient. If relatives are present, ask them if there is anything that they feel you should know about before seeing the patient and explain that they will have an opportunity to speak to you after the interview. Generally it is best to see adult patients alone.

In the interview room

Reintroduce yourself to the patient, as many will forget or mishear your name and you will want to use this as part of your cognitive assessment later. Explain the purpose of the interview, and say how much time you expect to have available. Explain that you need to write some notes, but say that they are a confidential record. (If the assessment is for medico-legal purposes, it should be clearly stated that what is said in the interview will be put in a report which may be given to third parties or placed before the court. In this situation the patient should be asked to consent in writing.) Generally, it is advisable to avoid lengthy interviews and best to collect lengthy information over a number of days.

History of presenting complaint

The main reasons for taking a history and performing the mental state examination can be lost when starting out in psychiatry, not least because the chaos of many of our patients is reflected in their presentation and in the telling of their story. Remember that you are taking the history and mental state so that you can make an assessment which helps you plan management. This assessment goes further than making an accurate ICD-10 diagnosis, although this is crucial. You essentially want to answer the question 'Why has this patient presented in this way at this point in time?' in order to form a management plan which really fits your patient's needs.

Start your interview with an open question such as 'What have you come to see me about?' or 'Are there any concerns that your family have about you?'. Do not write anything down yet; you should be looking at the patient and listening to him/her. Only start to write after you have heard the patient's current symptoms and have established the order in which the various complaints developed. Write an account in chronological order, giving duration of each complaint or problem. This account of the evolution of the patient's problems should include the social milieu within which s/he developed, highlighting any key precipitating events. The patient's symptoms, attributions (what the patient thinks caused the symptom) should be described, as well as how s/he tried to cope with his/her experience. The effects of any treatment taken should be noted. The effect of the patient's symptoms on his/her social functioning, occupational functioning, interpersonal functioning (family, marriage, sexual functioning, responsibility), and self-care (including eating, sleeping, weight, excretory functions, and substance use) should be described.

Precipitants

These may not have emerged in the patient's spontaneous account of precipitants and it is worthwhile screening for these, again because it informs management plans:

- life events (or anniversaries of life events)
- alcohol or drug misuse
- non-adherence to medications if any have been prescribed.

Suicidal thoughts and actions

This topic is dealt with more fully in Chapter 8, Special Problems (pp.115–18). The questions form a natural hierarchy, which one goes along as far as necessary.

- Do you feel that you have a future?
- Do you feel that life's not worth living?
- Do you ever feel completely hopeless?
- Do you ever feel you'd be better of dead and away from it all?
- Have you made any plans?
  (if overdose: have you handled the tablets?)
- Have you ever made an attempt to take your own life?
- What prevents you from doing it?
- Have you made any arrangements for your affairs after your death?

For other special topics, such as alcohol and drug problems, eating disorders, and sexual disorder, also see Chapter 8. For epilepsy and organic patients, see Chapter 5.

Life charts

It is often helpful to relate events in the patient's life to illnesses that s/he has had. Life charts are especially valuable if the patient has both a physical illness and psychological problem; the columns should then be age, life event, physical illness, and psychological illness. The 'physical illness' column may of course be omitted if there is nothing to record.

In its simplest form, there is a line for each year of the patient's life; but it may be more informative to use a non-linear timescale and to give more space to some key periods of the patient's life, and less to others.

When you have finished taking the history of the present complaint, **recapitulate this history back to the patient**. Ask 'Is that right?' and 'Is there anything else I should ask you?'. At this stage go on to the mental state (Chapter 4, p.64).

Family history

The amount of detail recorded will be influenced by the nature of the patient's illness. It is very helpful to draw a picture of the patient's family, using squares for males and circles for females. Enter the first name against symbol for sib. Those who have died are indicated by an oblique line through the circle or square, together with date of death and cause of death. Marriages ended by divorce are indicated by a double oblique line. An example is given in Figure 1.1.

You draw this figure with the patient's assistance and in full view. You then ask: 'Did anyone in your family suffer from a mental illness?', and if so enter details besides their symbol. This is the most informative way of collecting information about genetic loading (see also p.6). If parents have separated, indicate on the family tree the age of the patient at the time when the separation occurred. Also ask about alcohol and suicide history in family members.

Personal history

This should not be a mechanical procedure, but an opportunity to test ideas about the patient's life, depending upon the nature of his/her current problems. Test hypotheses about the patient, using a 'negotiating' style: 'I wonder whether…'

Family background

Ask the patient to describe his/her parents or step-parents: what were they like, how did patient get on with each of them? Where does the patient come in the sibship, and what are the achievements of each sib?

Family atmosphere

Ask about the general experience of being a child in that family. Were they happy times? If not, what was the problem? Ask about early childhood difficulties and general development. (See also Chapter 3).

Infancy and childhood

Were there birth difficulties? Was the patient separated from his/her mother in early life? (From informant: was mother depressed after birth?)

Who brought the patient up and where? What was the occupation of parents or care-giver? What was the general nature and quality of the relationship with each? Physical punishment? Neglect? Sexual abuse?

School

Did the patient have many friends? How popular? What was his/her age on leaving school and qualifications? How did the patient get on with teachers? Was s/he encouraged by teachers? How self-confident was s/he at school? Was the patient bullied? Did s/he truant?

Occupational history

This provides an opportunity to judge whether the patient realized his/her potential, and whether s/he has persistence. Frequent changes of job or leaving many jobs without good reason suggest an abnormal personality.

Age at first job? General areas of employment? Periods of unemployment and why? Frequency of job change? Current job: enjoyable, any problems?

Psychosexual history

Current 'partner', time with that person, difficulties, are they supportive? Previous partners. Age at first girl/boy friend (ask directly about both same and opposite sexual relationships). Age at puberty and first sexual experience. Any unwanted sexual experiences? Any unsafe sex? If the patient has a steady partner, ask about the relationship. Any children (details)?

Past psychiatric history

Illnesses, admissions, treatment, and episodes of self-harm.

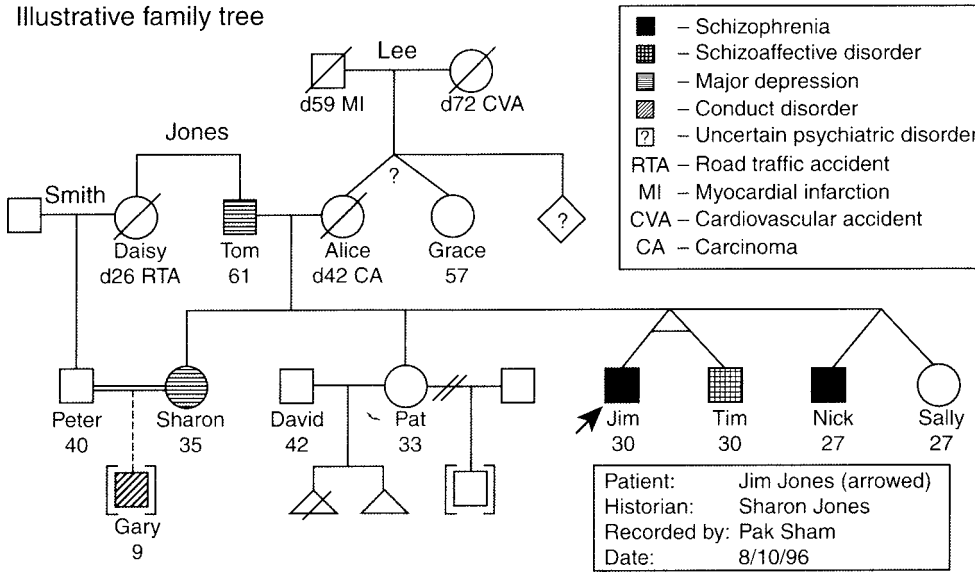

Fig. 1.1 Illustrative family tree

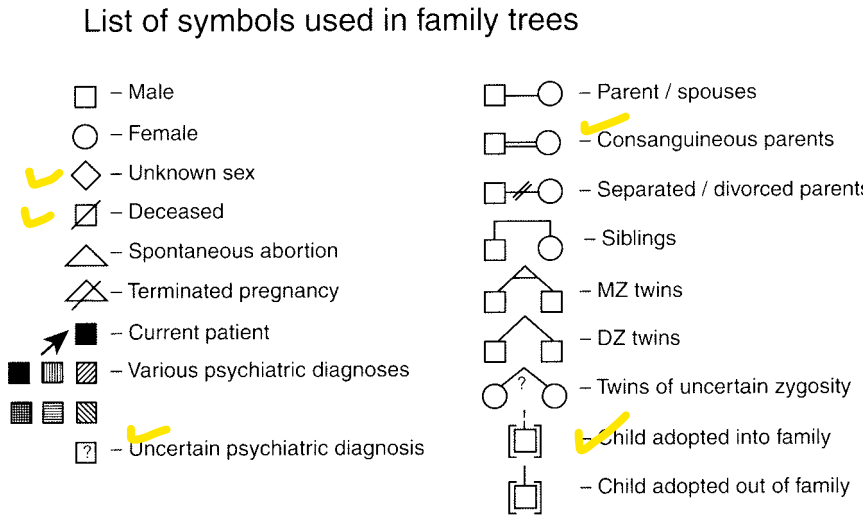
List of symbols used in family trees
– Male
– Female
– Unknown sex
– Deceased
– Spontaneous abortion
– Terminated pregnancy
– Current patient
– Various psychiatric diagnoses
?
– Uncertain psychiatric diagnosis
– Parent / spouses
– Consanguineous parents
– Separated / divorced parents
– Siblings
– MZ twins
– DZ twins
?
– Twins of uncertain zygosity
– Child adopted into family
– Child adopted out of family

Fig. 1.1 Contd.

Past and current medical and surgical history

Co-morbid physical illness is common in older patients and must be comprehensively assessed. All current medication, both regular and 'as required' should be documented. A collateral history from the patient's general practitioner (GP) may be helpful. The patient's view of his/her own health may be an important feature in the presenting complaint.

Alcohol use

All patients should be asked about their alcohol consumption. Screening aims to detect whether an alcohol problem is present and, if so, whether it is likely to respond to brief intervention or to require specialized treatment. Some commonly used screening questions are derived from the Alcohol Use Disorders Identification Test (AUDIT) (see Appendix 1).

- How often do you have a drink containing alcohol?
- How many drinks containing alcohol do you have on a typical day when you are drinking?
- How often do you have six or more drinks on one occasion?

These questions can be made less threatening by being incorporated into an assessment of general health/lifestyle or into the medical history.

Drug misuse

All patients should be asked about their use of illicit or over-the-counter drugs. However, for most patients a few brief screening questions will suffice.

- Are there any other tablets or medicines that you take, apart from those you get from your doctor?
- Is there anything you buy from the chemist, or get from friends?
- Have you used any (illegal) drugs such as cannabis, amphetamines/speed, ecstasy, cocaine/crack, LSD/acid, or heroin?
- What about tablets to settle your nerves or to help you sleep (such as temazepam or diazepam)?

Medication

Ask about current medication. Any allergies or problems with medication?

Forensic history

Ever been trouble with the law or had points on your driving licence? If so, record full details.

Social history

Accommodation, finances, home activities, outside activities, carers (for fuller details, see Chapter 2, pp.29–30).

Premorbid personality

Before you became unwell what were you like? Prompt patient for whether s/he had many friends; could s/he trust people; what was his/her temper like; how did s/he cope with life; how did s/he deal with criticism; was s/he very tidy? (Remember that information from an informant about personality is even more valuable than that from the patient, whose views may be influenced by the current illness.)

Interviews on emergency duty

The assessment while on emergency duty is likely to be much more focused on the presenting problem than the fuller assessment carried out on the ward.

Background information including the referral

Obtaining background information will enhance the efficiency and effectiveness of the assessment as well as promoting greater safety, but lays the clinician open to bias. In most situations, information is usually limited and in the form of a letter. Background information becomes particularly important in the context of the psychiatric emergency.

The most common psychiatric examination the trainee will have to undertake is the emergency assessment in the hospital setting. Typically, the patient will be heralded by a telephone call. For each call the following details should be elicited and clearly recorded in the notes, remembering that this may be the only opportunity to obtain some of the information:

- the name of the referrer and who they are in relation to the patient
- how you can contact them again should you wish to
- the patient's name and address (including postcode)
- general details including the referrer's concerns.

At this stage, before accepting the referral, if you are in doubt about whether or not the patient falls within your remit, explain this to the referring agent and arrange to call them back with the details (including telephone number) of the correct alternative.

Then ask the referrer for details of why they wish to send this patient to you both in terms of their concerns regarding the patient and how they feel that the patient should or might be helped. If the referral is a result of unusual behaviour, record a detailed account of who observed what. This is particularly important for patients who are brought by the police (e.g. under a Section 136) as this may be the only objective collaborative information available on the patient and the only opportunity to elicit and record it.

Where the referrer is a health care professional obtain as much information as possible. This can be grouped into:

- physical health problems (past and current including medication)
- mental health problems (past, current assessment, and medication)
- risk to self and risk to others (past and current).

Agree with the referrer where and when the patient will be seen.

Preparation of the room

The practical aspects of eliciting and recording information should be considered—quiet, well lit, private, and with a writing surface. Typically, the optimal seating arrangement is at an angle of 45°–90°, for example around one corner of a desk. Safety issues must always routinely be considered before seeing every patient; these include the following (see Chapter 7).

- Never sit the patient so that you are hemming him/her in. The furniture should be arranged such that it is easy for either of you to leave.
- Remove from sight any object that might be used as a weapon (e.g. letter-openers or large paperweights). In a volatile situation, the act of seeing a potential weapon can catalyse decompensation into violence.
- If there is a panic button in the room, know where it is, how it works, and whether or not it will summon aid after hours. If there is no panic button, know how to summon help.
- Avoid using rooms that are in an isolated area.
- Inform nursing colleagues what you are doing and how long you expect to be.
- If you believe that there is more than usual risk, arrange for several (nursing) colleagues to be close at hand. Before the interview discuss your concerns and how to manage an unwanted event.

Assessments on emergency duty

The work is of necessity problem focused, with only those aspects of the history and examination that are necessary to understand the nature of the patient's present problems. Thus the history of the present symptoms and a focused mental state examination are essential, as well as detailed enquiry about drugs and medications taken (or not taken) recently. Previous psychiatric history should be covered briefly, and an effort should be made to collect information from others who may be accompanying the patient.

The doctor will wish to admit all those whose illness represents a threat either to themselves or to others, unless satisfactory alternative care arrangements are available. Re-admissions of psychotic patients can sometimes be prevented if the keyworker is available, or if resources permit a very brief stay in a community hostel while medication is resumed.

Interviews in the outpatient department

Forming a management plan

It may be necessary to complete your information gathering from other sources before entering this stage of the assessment. If a relative is available, ask the patient whether s/he minds if you see them. (A parent of a child under 16 has a legal right to see you, but patients over the age of 16 can object.) Use your judgement about whether to have the relative in the room while the management plan is communicated to the patient. Other things being equal, it is usually to be preferred, as the relative's attitude to what you propose is likely to be a critical factor in determining compliance, and the patient may not remember everything that you say.

Ask the patient how s/he expected that you would help them. If his/her expectations sound reasonable, give him/her details of what you think would be the best course and ask him/her whether that sounds reasonable.

If the patient's expectations are quite different from your own, explain your reasons for preferring a different course of action. A relative if present, is often very useful at this point. Give your advice in small quantities, and get the patient to agree with what you are saying.

If the patient needs an **investigation**, explain why, what it will involve, and what steps s/he needs to take to get it done. If you are referring the patient to a colleague, tell him/her your colleague's name and the reason for the referral.

If you are **prescribing a drug**, say 'the drug I usually use for your problem is [name of drug]. Have you heard of that?' (If they have, have they ever been prescribed it, and did it help?) Tell the patient:

- the main effects of the drug
- its side effects
- how long they are likely to have to take it
- whether there is a discontinuation syndrome
- whether it is habit-forming.

If you are suggesting a **course of therapeutic interviews**, tell the patient:

- how many interviews
- how long each will last
- what the purpose of the interviews will be
- what you expect the patient to discuss during them

Get the patient to agree to the plan, or you may well have been wasting your time.

Assessment of the elderly patient

This is essentially the same as that of younger adults, but there are differences of emphasis that need consideration. Assessment is frequently complicated by the patient's **intellectual impairment, physical ill-health**, including hearing and visual disability, and **clouding of consciousness**. As a consequence it may be necessary to carry out the assessment over several sessions and essential to obtain a **collateral history** from a close relative or carer. Nowadays, the initial assessment will usually be carried out in the patient's own home.

Old-age psychiatry is largely concerned with four major diagnoses: dementia, delirium, depression, and delusional disorder (including schizophrenia). Clearly, neuroses, personality disorders, and substance abuse do occur in the elderly, but to simplify what follows, discussion will be limited to the four diagnostic groups listed above.

History of the presenting complaint

Bear in mind that some patients with dementia or delirium may lack insight. Direct questioning about memory function may also be helpful.

- Do you have any difficulty with your memory?
- Do you forget where you have left things more than you used to?
- Do you think that your memory is worse than that of other people of your age?

Other cognitive problems, such as dysphasia, dyspraxia, and agnosia, should also be asked about (see p.80).

Elderly patients may not admit to feeling 'depressed' or 'low in spirits'. Careful questioning about other depressive symptoms, such as suicidal ideas, diurnal variation, low self-esteem, hopelessness, guilt, insomnia, anorexia, and weight loss, will assist with making the diagnosis.

Paranoid or psychotic features may need to be elicited directly.

- Do you get on well with your neighbours or have you had any difficulty with them?
- Do you ever hear/see things that other people do not?
- Are people spying on you or plotting against you?
- Are people stealing from you?

Many patients with dementia present to psychiatric services because of associated psychotic, affective or behavioural disturbances, rather than the cognitive problems. **These are best elicited from an informant**. Common psychotic symptoms in dementia include:

- delusions of theft, persecution
- auditory and visual hallucinations
- misidentification syndromes.

Common behavioural problems include:

- wandering
- aggression
- urinary incontinence
- elements of the Kluver–Bucy syndrome (i.e. binge-eating, hyperorality, sexual disinhibition, misrecognition, rages, apathy, and hypermetamorphosis).

Ask whether symptoms had a sudden or gradual onset. The order in which symptoms developed is sometimes important, for example in differentiating depression with cognitive impairment from 'real' dementia, or in differentiating between different types of dementia.

Cognitive assessment

Most older people have no objections to cognitive assessment when it is introduced with tact. It is helpful to start off by asking whether the patient has experienced any problems with memory and concentration (and, if so, whether this has bothered them and what sort of things they find they forget). After this, the cognitive assessment may make more sense. A common preamble used in research instruments is as follows: 'I am going to ask a few questions about memory and concentration. Some of these questions may seem very easy and others might be quite difficult but we need to ask everyone the same questions'.

Where the patient permits formal testing, a short cognitive screening test such as the Abbreviated Mental Test (AMT) or the Mini-Mental State Examination (MMSE) can be used (see Appendix 2). For patients known to have dementia, the MMSE is helpful in giving an approximate idea of the severity of impairment. A high score may provide evidence against substantial cognitive impairment. It may also be helpful in future assessments to have an idea of previous function (and therefore it is important that, where possible, previous assessments are accessed to put any current score in context). It is vital to take previous education, levels of literacy, and sensory deficits into account when interpreting scores from these screening tests. For example, someone with high educational attainment may have clinically evident dementia and still achieve a maximum score on the MMSE. In addition, both screening tests have poor cross-cultural validity, and results should be interpreted with appropriate caution.

Cognitive screening tests such as the MMSE provide relatively little information concerning specific cognitive deficits. For example, memory impairment cannot be adequately assessed through the recall of three words. Frontal lobe function is also poorly assessed by this instrument. If cognitive impairment is suspected, a formal assessment should be carried out as outlined in Chapter 4.

Family history

Specifically, a history in first-degree relatives of:

- dementia, Parkinson's disease, mental illness
- heart or stroke disease, hypertension
- cancer including leukaemia
- Down's syndrome.

Personal history

Ask about traumatic experiences which occurred during wartime (or at other times) which still bother the patient or cause distress. Sexual activity should be asked about in a straightforward and direct way. It should not be assumed that sexual behaviour will have ceased simply because a person is old.

Ask about reaction to life events:

- retirement
- bereavement
- serious illness in the patient or a close relative

Elder abuse is increasingly recognized. The following neutral series of questions may allow further exploration of this difficult area:

- Has anyone shouted at or insulted you recently?
- Has anyone hit you or handled you roughly recently?
- Has anyone stopped you getting the help you need recently?

Social history

This follows the usual schema outlined in Chapter 2, pp.29–30. However, important areas in the elderly, other than housing and finance, include the following.

- Social network: what support is there from family/friends, clubs? what day-centres are attended and how frequently?
- Home-care support: does the patient receive meals-on-wheels, home-helps, and district nurses? how frequently? are they helpful?

Lastly, an account of the patients ability to perform activities of daily living should be obtained. This should include information on the following.

- Mobility: the use of walking aids; whether stairs can be climbed without help.
- Personal hygiene: washing, continence, using the toilet, and dressing. For example: can you wash yourself without help? do you have trouble controlling your bladder? can you dress yourself without help?
- domestic activities: cooking, laundry, housework, and paying bills.

Taking a collateral history

Attempts should be made to obtain a collateral history for all psychiatric assessments. In the case of older patients, the following information may be most accurately obtained from an informant:

- history of cognitive decline
- onset and course of cognitive decline, if suspected
- personality change (suggestive of frontal lobe pathology)
- behavioural disturbance associated with cognitive decline (see 'History of the presenting complaint')
- Activities of daily living and level of support (see 'Social history')
- In the presence of confabulation, ascertaining deficits in long-term memory as part of the mental state examination may be impossible without an informant.

In the collateral history, it is particularly important to investigate the extent of carer strain. This may be a component in the patient's presentation, is an important risk factor for elder abuse, and may affect later treatment decisions and prognosis.

Assessing patients with learning disability

People with mild learning disability can usually provide their own history; additional history from an informant will usually be needed when the patient is moderately or severely disabled.

Remember that learning disability is not in itself an emergency; it is a permanent condition. Learning disability does not protect against the development of other conditions.

Always obtain information on the nature and duration of any recent changes, particularly behavioural changes: the opportunity to obtain this information from a **key informant** may not arise again. In a genuine emergency, usually some **additional condition** has developed which may be either physical or mental.

- Always eliminate **pain** as a cause for an acute behavioural disturbance; pain may arise from a life-threatening condition.
- Ask about recent **seizures** or other epileptic phenomena.

If diagnosis of learning disability is in doubt ask the informant:

- Was this person's development delayed in childhood?
- Did this person attend a Special School?
- Did s/he learn to read and write?
- What jobs has this person held?
- Is this person losing any skills?
- Does anyone in the family have a learning disability or developmental abnormality?

Terminating the interview

Tell the patient what you are going to do (e.g. write to his/her doctor, discuss his/her case with a colleague) and when s/he will next be hearing from the hospital or, in the case of an inpatient, when s/he will next be seeing you. You may not know exactly when you will be available to see a ward patient, but in that case give them some idea, for example 'I'm next here on Thursday, and I'll try to see you for half an hour during the afternoon'. In the case of an outpatient, give him/her an appointment card with an identifying number on it. If you expect the patient to do anything, make sure that this has been clearly understood by either the patient or his/her relative.

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Chapter 2

Special assessments with adults

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Assessing early life experience

In the absence of a suitable informant, the patient may only be able to report what they have been told about their early years, the period of normal childhood amnesia. If they report amnesia for most of their childhood, there must be a strong suspicion that there have been events too painful to remember which have been actively obliterated. Significant events which probably will have influenced the persons early development, coping strategies, personality, relationship patterns, and vulnerabilities are as follows.

1. Puerperal illness of the mother, leading to actual separation or subtle deficiencies in early maternal care.
2. Siblings born in rapid succession: pregnancy can interfere with a mother's ability to be receptive to her infant's hostility towards its unborn sibling. This can lead to suppression of feelings of rivalry and jealousy in the child, mistakenly reported as lack of jealousy.
3. Twinship stresses mother, twins, and all the family. Rivalry between twins and their separate development may be obliterated in many ways if parents find it too painful and complex to deal with. Its reported absence is abnormal.
4. Death of a parent and bereavement reactions of the survivors can have a lasting effect. Who helped the subject to mourn?
5. Chronic illness, especially mental illness of a parent. Was it a family secret? What help did the family have from outside? Who became the 'parental child'?
6. Parental strife and separation, which inevitably leads to divided loyalties. A mother who cannot separate from a violent partner exposes her children to confusion. They want to but cannot protect her, and they cannot understand why she does not leave to protect herself.
7. Single parenthood: poverty, lack of emotional support, frequent changes of sexual partner, increased risk of child abuse by partners.
8. Frequent changes of domicile: ruptures peer relationships and disrupts schooling.
9. Bullying at school suggests poor self-esteem, poor social skills, and insecure early attachment pattern.
10. Frequent hospitalizations: separations, painful operations, disruption of schooling and peer relations, over-anxious or disengaged parents.
11. Major environmental failure: in and out of care, foster homes, children's homes, childhood sexual and physical abuse, neglect, emotional deprivation.

Memories of sexual abuse

There is now compelling evidence from well-conducted case–control studies that sexual abuse during childhood (CSA) is followed by higher rates of depression and anxiety during childhood and early adult life, greater incidence of deliberate self-harm, and eating disorders during adolescence and early adult life. Since sexual abuse of children is commonly accompanied by both physical abuse and poor care, it is difficult to disentangle the specific ill effects of each kind of abuse. However, not all patients who give vivid descriptions of sexual abuse have in fact been abused, and false memories are especially likely to occur after misguided 'therapeutic' efforts to recover such memories. The situation is complicated by the fact that some people who were actually abused have repressed their memories of the abuse, a fact that leads some self-styled therapists to embark on treatment designed to recover such memories.

Psychiatric practice and memories of sexual abuse

Obtaining a psychiatric history which may include sexual abuse poses difficulties. Repeated admissions to psychiatric hospitals leads to the history being recounted on many occasions. What we know about memory is that if there is extensive rehearsal of an imagined event the person can believe the event happened. The memory can become highly detailed and vivid to the person. The event can be altered in matters of detail by suggestion and leading questions. It is common practice for the patient's account to be recorded in psychiatric notes without any attempt to question the source or reliability of the memory. Indeed, the American Psychiatric Association report stated

> Psychiatrists should maintain *an empathic, non-judgmental, neutral stance* towards memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patients difficulties or the veracity of the patients reports. A strong belief by the psychiatrist that sexual abuse, or other factors, are or are not the cause of the patient's problems is likely to interfere with appropriate assessment and treatment. Many individuals who have experienced sexual abuse have a history of not being believed by their parents, or others in whom they have put their trust. Expression of disbelief is likely to cause the patient further pain and decrease his/her willingness to seek psychiatric treatment. Similarly clinicians should not exert pressure on patients to believe in events that may have not occurred, or to prematurely disrupt important relationships or make other important decisions based on these speculations.

One of the strongest criteria in assessing the reliability of a memory is the accuracy with which it is anchored in place and time. However, it may be difficult to establish these sorts of facts in the context of the approach (empathic non-judgemental) defined above. Thus the history

from the patient may be unreliable and the process of medical treatment may further contribute to faulty recollection.

Recovered false memories

'Recovered memories' are typically reported in the course of therapies which employ memory recovery techniques, including hypnosis (especially hypnotic regression), journalling, guided imagery, guided meditation, and the use of so-called 'truth drugs'. Therapists practising these techniques state that the memories occur in the context of amnesia at the start of therapy, such that clients giving their life history would not be aware of abuse as a child.

Absent memories: amnesia for abuse

In one study, children who had presented for medical care immediately following sexual abuse were seen as adults on average 17 years later. Over a third (38 per cent) appeared to have no memory of their early abuse. Loss of memory was most common if the abuse occurred when they were young and was perpetrated by someone they knew.

Normal memory

To a degree all memories are unreliable. They are not held like video tapes in the mind to be replayed at recall. Rather, when a memory is cued it is processed even prior to the stage it reaches awareness. This processing can include the incorporation of general knowledge or material from another record. Following the remembering, information will be stored as a record of the remembering. The next time the cycle of remembering is entered the recall may be for the original, or may be for the previous recall. Not every detail of an event is stored in memory. When an event is recalled it might need elaborating before it is intelligible to consciousness. What we are conscious of is a mixture of reproduction and reconstruction. Reconstructive memory is characterized by conflation of different events, filling out detail, and importation of information. Nothing can be recalled accurately from before the first birthday and little from before the second. Poor memory from before the fourth birthday is normal.

The factors which influence the degree of reconstruction include:

- the personal significance of the event
- its emotive content
- the time elapsed between the event occurring and its recall
- the age at which the event occurred
- the reasons why the person is remembering the event and the circumstances of recall.

False beliefs and incorrect memories

There is a great deal of evidence for incorrect memories, i.e. where an event has happened but the details are wrongly recalled. This is because of the mental processing, some of it unconscious, that occurs when memories are recollected. The extent to which this occurs is outside the individual's awareness. There is an unstable relationship between confidence and accuracy

Abnormal mental states are also likely to lead to errors in the reconstruction of memories. This is obvious in psychotic states but also occurs

in extreme emotional states. In such states of mind there are errors and biases in memory processing, evaluative judgements, and overall information processing.

Informants

The fact that memories can be unreliable is recognized in psychiatry and is why informants are often used to corroborate the history. This is recognized as good psychiatric practice. The history should be compiled from information elicited both from the patient and from one or more informants. The informant's account will not only amplify the patient's report of factual detail but will supplement the patient's account. Clinicians bear a heavy responsibility to do no harm. The desire to help the victims of childhood abuse heal is more than justified, but clinicians are urged to reflect upon the damage done by false accusations. Accepting the truth of what appear to be long forgotten memories elicited by therapy without corroboration can seriously injure and disrupt the lives of innocent people. For this reason many psychiatrists feel uncomfortable if they attempt to obtain corroboration in this area. They are uncertain what questions they should ask and of whom they should ask them. Are they not breaking confidentiality if they attempt to do this?

The corroborative evidence that is useful in a psychiatric history is different from that required for forensic reasons. Open broad questions can be used. For example, if there is a history of CSA, it would be reasonable to ask the parents, other relatives, and schools whether any difficulties or concerns were noted during the child's development.

Sexual disorders and couple relationship problems

Sexual history

- Age at puberty (voice breaking, shaving, menarche).
- Age at which first ejaculation occurred.
- Age at first masturbation. How was this regarded? Fantasies? Anxieties?
- Attitudes of parents to sexual matters.
- Sexual seduction or childhood sexual abuse?
- Any unusual sexual preferences? Fantasies? Activities?
- Homosexual or heterosexual orientation (fantasies, desires, and experiences)?
- Any gender dysphoria, including non-arousing cross-dressing?
- Previous sexual experiences and relationships including painful or traumatic ones.
- Age at first intercourse.
- Current sex life (if any). Marital, extramarital, visiting, or cohabiting?
- Current frequency of masturbation?
- Level of sexual drive. Any changes during this illness?
- Contraception? Safe sex? Sexually transmitted diseases?
- Sexual dysfunctions. Desire, arousal, or orgasm? Partner satisfied?
- Discrepancy in sexual interest between partners.
- Menopause? Hysterectomy? Hormone replacement?

Marital and relationship history

- Number of previous engagements or serious relationships.
- Difficulties in these and reasons for break-up.
- Age at present marriage (or cohabitation): reasons (e.g. pregnancy)
- Age, occupation, health, and personality of partner.
- Quality of relationship: threat of separation or divorce.
- Reaction of partner to patient's present illness.
- Communication, negotiation of differences, ability to confide, empathy.
- Dominance, submission, distance, trust, fidelity, jealousy.
- Problems, past and present, arguments, violence.
- Death of spouse? Separation (temporary or permanent) or divorce?
- Changes in sexual activities during relationship (e.g. ageing effects).
- Obstetric history: pregnancies, live births, terminations, and miscarriages.

Children (present or earlier relationships)

- Ages, genders, names.
- Present and past health. Any psychiatric problems or treatment?
- Attitude towards children and future pregnancies.
- Proximity and contact with children not now living at home.

Assessing personality

Why assess personality?

Premorbid personality colours the presentation of mental illness. In addition, personality is one of the determinants of illness behaviour and adherence to treatment. The assessment of premorbid personality is therefore, an essential part of a psychiatric assessment. In addition, personality disorders are common and burdensome conditions. Epidemiological research has shown that the prevalence of personality disorders steadily increases with each level of care: 10 per cent in the community, 20 per cent in primary care and between 30–60 per cent among samples of psychiatric patients as a main or ancillary diagnosis. People with a personality disorder have an increased risk of suicide, accidents, mental illness, and drug misuse, and respond less well to treatment for mental illness. They are heavy users of health services and are therefore, frequently encountered in clinical practice.

Definitions

Personality is a term used to describe enduring traits and behaviours that differentiate individuals from each other. Personality traits are usually present since adolescence, stable over time, and evident in a range of different environments. Personality disorders, on the other hand, are mental disorders characterized by enduring patterns of inner experience and behaviour that deviate from the individual's culture and are pervasive and inflexible. A core-defining feature of personality disorders is that the traits and associated behaviour are associated with significant personal, social, or occupational impairment. The ICD-10 categories of personality correspond roughly to the DSM-IV categories. DSM-IV

recognizes three 'clusters' of personality disorder, brief details of which are give in Table 2.1.

The three DSM-IV clusters are used widely by clinicians and have been shown to be useful in distinguishing different populations of psychiatric patients (Reich and Thompson 1987).

Table 2.1 Clusters of personality disorders from DSM-IV

Cluster A ('odd or eccentric' types)	Paranoid, schizoid, and schizotypal personality disorders
Cluster B ('dramatic, emotional, or erratic' types)	Histrionic, narcissistic, antisocial, and borderline personality disorders
Cluster C ('anxious and fearful' types)	Obsessive–compulsive, avoidant, and dependent

Categories or dimensions?

Doctors tend to prefer the use of categories when describing abnormal states. However, the categorical model of personality disturbance has its limitations. Criteria for categories of personality disorder frequently overlap and clinicians often disagree on whether categories are present or not. In fact, personality is probably more accurately conceptualized in terms of variation along the 'Big Five' dimensions of neuroticism, extroversion, openness to experience, agreeableness, and conscientiousness (Digman 1990). However, although the research evidence favours dimensions, categories lead more readily to treatment decisions and convey more vividly the disturbance demonstrated by the highly abnormal people that psychiatrists are called on to assess.

Use the term 'personality disorder' cautiously!

People with personality disorders are often the most difficult people to be encountered in clinical practice. They do not readily reward staff and often intrude directly on their feelings. However, it is important to avoid using the term 'personality disorder' merely to explain disagreeable behaviour. There are stigmatizing effects of applying the label of personality disorder. Therefore, before the diagnosis is made, positive evidence must be sought.

Who should provide information?

Self-description is difficult and, in a clinical situation, the presence of mental illness may distort the assessment of personality. For these reasons, in addition to the patient's account of him/herself, it is also desirable to obtain a corroborative account from an informant. The informant should be someone who has known the patient when s/he was free of symptoms for a number of years and preferably in more than one circumstance. The interview should enquire into positive as well as negative aspects of the patient's personality, as these may also guide the management strategy.

How should the interview proceed?

It is important to be sure that the informant or patient (as his/her own informant) understands that this interview concerns a time of life when the patient was well. Agree on that time (e.g. 5 years ago or before the

marriage broke down) and focus the interview on that period. Begin by asking the informant an open-ended question, to describe in his/her own words how the patient was at that time. This response itself may indicate which diagnostic category of personality may be appropriate. However, if uninformative, the following more specific questions will probe for one of the ICD-10 categories.

Start your discussion of personality with a general screening question, such as 'How does s/he get on with other people?' Go on to the questions listed in Table 2.2, asking clarifying questions only if you have a positive reply to a screening question.

Table 2.2 Screening and clarifying questions for personality disorder

Screening question (group)	Clarifying questions
Does s/he trust other people? (paranoid)	Is s/he a suspicious person who misinterprets the actions of others as threatening or demeaning? Does s/he consistently bear grudges?
Would you describe him/her as a loner? (schizoid)	Does s/he almost always prefer to do solitary things? Is s/he a detached, aloof, or cold person?
Does s/he have difficulty controlling his/her temper? (dissocial)	Is s/he consistently irresponsible? Does s/he lack remorse when s/he has done something wrong?
Is s/he impulsive? (emotionally unstable)	Does s/he have an unstable mood? Does s/he make frantic efforts to avoid abandonment?
Does s/he dislike situations where s/he is not the centre of attention (histrionic)	Is s/he a dramatic or theatrical person? Do his/her emotions change rapidly (over the course of minutes or hours, not days)
Is s/he a worrier or a shy person? (anxious)	Does s/he view him/herself as inferior compared with others? Is s/he unwilling to become involved with people unless s/he is certain of being liked?
Does s/he depend on others a lot? (dependent)	Does s/he allow others to make the most of his/her important decisions? Does s/he have difficulty expressing disagreement with others for fear of rejection?
Does s/he have unusually high standards at work or home? (anankastic)	Is s/he so preoccupied with details and rules that the main point of an activity is lost? Does s/he insist that others do things the way s/he wants them to be done?

Any one of these probes may point to one of the ICD-10 categories. Therefore the interviewer should follow with subsidiary questions that concern the additional features of that category (see ICD-10 for further details). In addition, the informant should be asked to indicate whether these features were generally present (e.g. not just at work) and whether the personality seemed responsible for personal suffering (e.g. periods of distress or unhappiness) or handicap in social or occupational life. From this information, abnormal premorbid personality may be identified or personality disorder diagnosed. If the patient is to be the informant, then the same procedure can be followed. A number of reliable standardized assessment procedures for personality disorders now exist, and ideally one of these should be used as part of the assessment. Examples of reliable assessment measures, developed in the UK for use in routine clinical settings, are the Standardized Assessment of Personality and the Personality Assessment Schedule.

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Assessing family relationships

There are many reasons why it can be valuable to interview the family of the presenting patient (index patient), ranging from obtaining a good description of fits, fugues, and other altered states of consciousness to an examination of the family dynamics, for example to uncover possible maintaining influences in relation to the patient who relapses when a discharge date is decided. The index patient is of course included in the family meeting.

As a general rule, the earlier the family can be included in the investigation and treatment of a problem the better, assuming that the index patient is agreeable. It is important for the interviewer to be alert to the strengths and resources of the family who will usually have tried hard to support and help their ill member before calling in the professionals. By the time they see you they may be feeling demoralized and helpless. They may be angry with the patient and secretly blaming themselves or each other. Under these circumstances it is crucial that you do not add to their guilt or sense of failure.

How to manage a family interview

After initial introductions and an explanation of the setting (one-way screen, closed circuit television), start by thanking the family members for coming and acknowledging interruptions to school and work. Then state the purpose of the meeting by inviting them to help you to help the index patient, as indeed they are experts by virtue of having known him/her for longer and before s/he became ill. It is usually best to start by

asking for a description of the problem, being sure to hear from each member of the family how s/he sees it.

Even at this early stage one often obtains startlingly different descriptions of the problem. It is valuable to define the problem as it affects the family now, and clarify that this may be different from how the problem began. The focus at this early stage in the interview is to translate the problem (described as an attribute of the index patient) into statements about relationships and differences in relationships among the family members. At all times it is important to note their non-verbal messages: posture, eye contact, interruptions, and emotional states (detachment, fear, sadness, etc.).

One may enquire into current alliances in relation to the present problem (who feels most upset by (the problem), who notices first, who becomes impatient first), obtaining a ranking of all members in relation to each question. It is very useful to track sequences of behaviour around the problem as this provides a detailed pattern of activity which is often stereotypic.

It is the family's attempt at a solution which has itself become part of the problem. By asking different family members for their explanation of how the pattern has evolved or why particular members take up particular roles in the sequence of behaviour it is usually possible to uncover differences of opinion about what happens. It can be useful to ask what other approaches to the problem have been tried and why they were abandoned.

When you feel that you have a clear picture of how the family tries and fails to help in relation to the immediate problem, it is time to enquire into how the problem affects other aspects of the family's life together. How does the family regroup when the index patient is ill, or away in hospital? Who takes over his/her tasks? Who misses him/her most? By comparing and conducting current arrangements and role assignments with those before the problem began, certain hypotheses about what function the problem serves will emerge.

The final part of an initial family interview involves establishing with the family members whether or not they are willing to continue to work together with you in arriving at a better understanding of the problem and finding a way either of resolving it or living with it. Alternatively, you may discover that there is such hostility towards the index patient or so much chaos, discord, or obstructiveness that it is clear that the patient will have to be helped to live apart from his/her family. Although painful, this is usually much better accepted by the patient if the limits of what each family member is willing to offer in terms of help and support are clear to him/her. For example, a couple who had both divorced and remarried each had to say to their adult chronic schizophrenic daughter, in front of each other: 'You cannot, under any circumstances, live with me'. In this case the uncertainty had been perpetuated by each one saying: 'Wait until you are better. Then you can live with me or possibly the other parent'.

There is so much information to take in, record, and interpret in a family interview that it is of great value to have an non-involved observer or a video recording. Any kind of electronic record requires the informed

consent of the family at the beginning of the interview with the option to delete the recording at the end.

Your observations may be recorded under the following headings.

Description of family members present

The family includes all those living in the same household, but children who have left home and relatives in other households who are significantly involved may be included.

Note absent members.

List names, ages, physical appearance, and mental state.

Description of problem

- Use the words of family members.
- Include problem as it began and the problem now.
- Record stereotypic pattern if elicited.

The stage of the family life-cycle

- **Courtship**, marriage and the honeymoon period.
- The **first child** alters the couple's view of themselves and each other as they make space for the baby.
- **Subsequent children** each make demands for adjustment on existing family members.
- The **children reach adolescence** with the coming of puberty, sexual awakening, and bids for independence, and face the challenge of leaving home.
- The **empty nest**, as the last child leaves home. The couple, having reached mid-life or later, face the dependence, illness, or death of their own parents, as well as what remains of their own life together.

Crises in families often arise when transition to the next stage is required, but for some reason cannot be successfully negotiated. Crises may result in a symptomatic member or marital difficulties, or both.

The genogram or family tree

This can be a powerful tool for eliciting transgenerational resonances. It is important to ask about stillbirths and other premature deaths; note the ages and date of death of grandparents, siblings, and children. Crises in the life-cycles of the previous generation (the parents' families of origin) may illuminate difficulties in the presenting family. The occupation of each person should be indicated, if known.

The family structure

This refers to the existence of appropriate or inappropriate boundaries between different parts of the family: the boundary between the couple and each of their families of origin, as well as parents and children. Are there transgenerational alliances: father and daughter; mother and son; grandmother, mother, and daughter? Is one member of the family isolated (e.g. father) or scapegoated (e.g. a child who is different from the other siblings)? Facts informing these judgements can be elicited by asking about the routine daily activities: who does what with whom? How are mealtimes, bedtimes, housework, household chores, and leisure activities

arranged? How are decisions made? Do the couple consult one another? If not, who is consulted and who is not? How are conflicts negotiated and resolved? Who has the final say? Who controls the finances? In families with an ill adolescent, the hierarchy is sometimes inverted; the parents are capriciously governed by their offspring.

Family roles and attitudes

In response to the questions above it should also become clear whether particular family members are assigned by common agreement to certain roles, and how power, authority, and gender-specific activities are distributed. Implicit in these roles will be shared attitudes, although when made explicit, differences of opinion may emerge. Acceptance of role assignment may be a way of avoiding conflict. Cultural and religious attitudes are often expressed in role assignments and expectations based on gender and birth order. A good way to find out more about cultural and religious views with which the interviewer is unfamiliar is to acknowledge difference and ignorance and ask. It also allows the family members to describe what it is like for them to belong to an ethnic minority and the impact of the dominant culture on their lives.

Communication and emotional climate

These aspects of the description of family relationships will first of all depend upon your observations of the family as they have responded to your questioning. Supplementary questioning can clarify how the various family members experience and think about each other. For example, if the mother tends to answer for her daughter, one can ask the daughter 'Does your mother always know what you are thinking?' or ask the father or other relative 'How does your daughter manage to get her mother to speak for her?' or ask a sibling 'Does your mother always speak for your sister or are there times when your sister can speak for herself?'.

Other common patterns are as follows: one family member is frequently interrupted by another; one member is habitually silent and ignored, or disengaged, or overemotional; everyone talks at once; no one finishes a sentence; no one listens to anyone else; one member habitually defers to another.

There may be obvious omissions or evasions. Communication may be clear and direct or contradictory or obfuscating.

The emotional atmosphere may be free or frozen, cool and distant, or intensely over-involved. Dyads or subsystems may be locked in superiority and submission, condescension and self-effacement, or cruelty and humiliation.

The hypothesis

This is an attempt to describe the problem in systemic terms, i.e. what maintains and prevents resolution of the problem in terms of the contribution of each family member who, it is predicted, both gains and suffers from the status quo.

Assessing the social state

The social state provides a structure of five main headings, for each of which four main categories of information and assessment can be reported. The four categories or columns will not all be needed if significant problems are absent. The format must allow for the possibility that only a very brief or highly distilled report will be required (or feasible) in some cases, while others may require a lot of detailed information.

The social state should be inserted in the notes after the history and before the mental state examination. In this position it supplants and extends the information which may at present be recorded in the history, partly under 'previous personality' and partly under 'social history' or 'current circumstances'.

Some aspects of the social state, notably cultural assessments and educational achievements, have been commented on elsewhere.

Under each heading, try and distinguish between the following.

- **Facts** – aims to record the situation in terms of reported objective information from the patient or identified others (including the assessor).
- **Problems** – comprises two kinds of element, which may be reported separately: subjective difficulties reported by the patient and objective difficulties observed by others.
- **Services** – reports provisions already made at the time of assessment to alleviate some, but not necessarily all, the problems identified. Inadequacies or overprovision may be commented on, but this area of the assessment report is not the place to record proposals about management.
- **Strengths** – invites the assessor to report on positive features of the patient's social opportunities and functioning, which may serve to counterbalance the commonly prevailing negative tone of many psychiatric assessments by highlighting positive resources, relationships, and potentialities.

Accommodation

Under this heading are described the physical nature of the patient's residence and the identity of the people who normally provide the immediate social environment. The aim is to assess the type and quality of physical resources available to the patient in the home and to name the people who share the accommodation. Subheadings include the following.

- Type of accommodation
- Physical amenities, personal space
- Quality of accommodation
- Identity of other people sharing the accommodation
- Ease of access
- Physical security
- Nature and quality of neighbourhood

Finances

This requires a description of the patient's financial status and use of welfare benefits in order to assess income, monetary assets, liabilities, and capacities to handle money. Subheadings include the following.

- Sources of income (including welfare benefits)
- Capital, savings, other assets
- Expenditure (including special liabilities such as gambling)
- Debts (including threats of punitive action such as withdrawal of services or eviction)
- Does patient contribute to, or is s/he dependent upon, the household?
- Budgeting capacity

Home activities

The focus here is on daily events and activities within the home and the provision of both informal and professional support and services from people visiting the home. Subheadings include the following.

- Way of spending a typical day (includes waking and rising, daily routines)
- Daily living skills (including personal hygiene, laundry, cooking, cleaning)
- Recreational activities

Outside activities

The patient is seen in relationship to the local and wider community outside the home residence. Subheadings include the following.

- Occupation
- Social contacts (family, friends, others)
- Visitors, relationships with immediate neighbours
- Shopping
- Travel
- Use of public amenities (e.g. pubs, cinema)
- Other outside leisure activities
- Religious observance
- Holidays

Carer's assessment

Under this heading are listed the people who are individually identifiable as accepting a special responsibility for promoting and sustaining the patient's welfare. They may include family members, friends, other informal contacts, and members of professional agencies. Professional carers include staff members of NHS agencies (GP, psychiatric services, etc., and relationships with them), staff members of other statutory agencies (social services etc.), and members of voluntary bodies (including religious organizations).

- Name, address, and telephone number of carer
- What is the relationship with the patient?
- How long have you been the carer?
- Is the patient living with you?
- What help do you provide?
- What effect does being a carer have on you?
- Is the level of care you provide likely to change?

Cross-cultural assessments in psychiatry

A patient's history must be approached in terms of his/her personal, family, and cultural involvement. The individual's cultural identity can be elicited from personal explanations by patients and their carers and the meanings that they assign to their distress. The main goal of this section is to highlight some of the areas which may influence the psychiatrist's perceptions and stereotypes of individuals whose ethnic and racial background and cultural influences may be different from those of the psychiatrist.

The doctor–patient interaction is affected by training, past experience, social class, and ethnicity on the doctor's part and by past experiences of the illness and services, educational and social background, and ethnicity of the patient. It is, of course, likely that gender, sexual orientation, socioeconomic or educational status, lifestyle, job, or professional role may overshadow the ethnic or racial identity of the patient. These factors may give a differential power to the clinician which may further contribute to a sense of alienation among patients from black and ethnic minority groups. Cultures do not remain static and individuals change their cultural values.

Mental health services are frequently looked down upon by members of ethnic minorities because the institutions may be seen to replace their personal support systems, may reflect Western dominant cultural values and implicit racism, and may rely on psychological formulations which ignore cultural values and norms of ethnic minorities. These institutions may also be seen to be pandering to those who conform with the dominant culture.

Communication and cultural distance

The principles outlined here are not a recipe for 'how to do it' culture by culture, but are general guidelines aimed at ensuring safe and sensitive practice. Cultures influence the way idioms of distress are expressed and where and when help is sought. Cultures can keep the symptoms going and can also influence patterns of social support. If the clinician does not know about a particular culture, it is important to find out about its essential features, including taboos, dietary restrictions, rites of passage, and religious values, before commencing the assessment. The first and preferred language in which the patient communicates must be identified as soon as practical. If this is not English, an appropriate interpreter may be required who can also act as an adviser on non-verbal communication as well as identifying idioms of distress and 'emotional' words used by the patient. Family members should not be used routinely for interpretation, and using children is fraught with particular difficulties.

Box 2.1 Setting up the assessment

- Be aware of your own culture and limitations.
- Be aware of your skills and how these can be blunted or affected by your culture.
- Assess predominant group within which the patient has cultural status.
- Find out the patient's skills and strengths.
- Find out the carers' needs—their language limitations, sense of urgency or crisis, and realistic capacity of coping strategies available to them.
- Meet with the interpreter before the assessment commences to identify their knowledge of culture, identify sources of difference (e.g. dialect, tribe, religion).
- Confidentiality.

As in assessing any patient for the first time, the first step must be an unstructured ten minutes of 'emotional orientation', during which idioms of distress and key emotional words and terms can be identified which will give a clue towards the direction in which the assessment must proceed (Box 2.1).

Management of patients from other cultures

The management of patients from other cultures must be balanced with the patient's wishes, taking account of cultural distance and that the clinician may be making a clinical decision on the basis of information which may be less than adequate. Therefore a careful risk assessment is warranted. As in assessing any other patient, if the problem is not urgent and there is sufficient time, a further assessment period should be set aside. This will allow further gathering of details about the patient's presentation, information from past records, other health professionals, family members, etc., and it will also provide an additional opportunity of garnering information on the patient's culture from members of the group and community leaders. The patient should be made aware that this is happening.

It is good clinical practice to discuss diagnosis and management plans with the patient and his/her advocates or identified family members. The appropriateness of aetiological and diagnostic inferences should be considered with an awareness of cultural norms. If the patient and other interested parties, including advocates, disagree with the intended management plan, clinicians must arrange to meet again and continue to discuss risk assessment.

Some cultures have a great respect for the health profession, doctors in particular, such that their members may not confront, question, disagree with, or point out the problems that they may be facing. These may manifest as selective omission of medication, inaccurate reporting of

symptoms, consultation with other healers, and pluralism in treatment which may deter the patient from attending statutory services. Other healers may more commonly offer excessive reassurance or promise of miraculous cures which will encourage patients to disengage with the statutory sector.

Box 2.2 Good practice points

- For each party involved in consultation elicit first language, religion, self-defined ethnicity, identification with specific cultural groups.
- Define and redefine terms used by you and the patient to ensure shared understanding of problems.
- Identify emotional idioms of distress and develop a shared vocabulary with the patient.
- Ask for clarification if symptoms or signs that appear unusual or unfamiliar.
- Assume nothing about the patient. Do not be judgemental about patterns of communication or domination of the clinical interview by one family member—this may be cultural or the family style of communication.
- Be sensitive to the effects of your action, the setting, or the referral mode which jeopardize trust. Communicate total confidentiality. Identify the scenario where the patient may be most comfortable and relaxed (e.g. with family, alone).
- Be sensitive to religious and social taboos.
- Do not ask children to interpret. Avoid relatives interpreting unless it is an emergency and delay will be detrimental to the patient.
- Involve patient advocates early with the patient's consent.
- Discuss the findings with an independent person properly familiar with the culture within the bounds of strict confidentiality.

Assessing the mental state across cultures

Assessment of the mental state must be thorough and detailed as with any other patient. However, where the patient does not share the mental health professional's culture (regardless of skin colour), any symptoms and signs must be appraised critically in a cultural context and the appraisal revisited in response to the emergence of more information.

Behaviour

Behaviours which may appear odd or bizarre to the assessing clinician may have a culturally sanctioned role. For example, speaking in tongues, excessive religiosity, and trance possession may be culturally sanctioned. These phenomena can only be evaluated by carefully recording the behaviour, the patient's explanation for it, and the response of the family and cultural group to it. These views, if a sign of illness, may change as the patient recovers and become important signs by which the patients, their carers, and others in the folk sector may identify a relapse in the

future. Unusual behaviour which is not clearly understandable should not readily be assigned as evidence of psychosis without due attention to the adaptive/coping potential of the behaviour

Aggression

Aggression is often labelled as being a manifestation of psychosis. Potential aggression is especially difficult to anticipate, and the interviewer may err on the side of caution by intervening too early if feeling threatened. Early intervention may well jeopardize any future treatment alliance. The only way to assess a potentially aggressive patient is to be clear about the safety of the assessors and of those around the patient (see p.105). There may be cultural norms of frustration, conflict resolution, and aggression sanctions. The clinician must avoid anticipated fear of assault and uncertainty about a patient whose cultural values, norms, and mores are different.

Hallucinations

The exact experiences and consistency, and especially differentiation from illusions and suggestibility states, must be ascertained. If the patient uses figures of speech inexactly to articulate his/her illness experience, the clinician must avoid erroneously identifying them as hallucinations. The presence of visual phenomena are especially difficult to locate firmly within the standard psychopathology framework.

Delusions

The traditional definition of delusion does take the role of culture and its context into account. There is, of course, a hypothetical possibility that if the examiner is not clear about the cultural values a delusional experience may be misattributed. Religious ideas, culturally sanctioned explanations, and spiritual or cosmic explanations must be carefully identified and documented verbatim. Do not just record your impressions. Always consider alternative reasons for a patient's beliefs with his/her relatives or advocates. Again record their responses intact. If a belief is culturally unfamiliar and is coupled with functional impairment or culturally inappropriate (with the patient's culture) behaviour, it is likely to be a sign of illness.

Cognitive assessment

The standard cognitive assessment may yield very little diagnostic psychopathology if used blindly across cultures, especially with different languages. It is better to obtain third-party information on the memory failure and intellectual decline. If schedules of cognitive assessment are available in the patient's primary language, these must be employed, bearing in mind the patient's level of education. Again, the help of an advocate or a team member who speaks the patient's first language can be invaluable

Assessing data in the history

Adverse events

Do not assume that life events, adverse or otherwise, have the same significance for patients as they do for you or that they have only the significance described previously in the literature. Flexible enquiry will accurately elicit the impact of a patient's experiences. Similarly, hospital admission or separation from children may be more traumatic than one might imagine, perhaps with culturally unacceptable implications.

World view

This is the patient's perspective of the consultation and his/her perspective on this emotional distress. World view is the personal lens through which people differentially interpret events. This can be further divided into group and individual identity, and the patient's beliefs, values, and cognitive perceptions of the distress and the help being offered. This can only be ascertained after several semistructured meetings with patients, family, advocates, and religious and community spokespeople as nominated by the patient. This will give a profile of events, thought, and approaches to the problems of living deployed by a patient living in a majority culture which may be perceived as hostile. Such collation of information will provide culturally sensitive data.

Acculturation

With increasing contact with other cultures, whether living in close proximity to them or not, and the globalization of cultures, cultural expectations and behaviours will vary across generations. Acculturation must be seen as a multidimensional phenomenon which reflects the changes an individual goes through when s/he is exposed to a new culture. The concept of self varies across cultures, and changes brought about by acculturation will also vary. Acculturation is a feature for the individual, families, religious groups and other culturally similar local groupings. It is not identical at each level and it is possible that degrees of acculturation will vary across different members of the family. Idioms of distress and expression of such distress together with help-seeking are all linked with processes of acculturation. Acculturation can be assessed by determining the period since migration and the reasons for migration. It may be worthwhile asking about the motives, patterns, and difficulties during and after migration as well as about coping and adjustment. Acculturation can be assessed by focusing on areas of religious activity, preferred dietary patterns, preferred leisure activities, and attitudes to traditional patterns of behaviour in the community (see Box 2.3).

Box 2.3 Assessment of acculturation: broad headings

- Religion
  - Practice
  - Frequency
  - Who attends? Where?
- Languages
  - Spoken
  - Where?
  - Frequency?
- Marriage/family
  - Type
  - Attitudes to marriage
  - Responsibility at home? Gender roles?
  - Arranged marriages?
- Employment
  - Working with others of same ethnicity?
  - Relationship?
  - Work ethic?
- Leisure activities
  - Which interests?
  - Languages spoken
  - Films? Music? Preference.
- Food
  - Type?
  - Shopping, where?
- Aspiration and attitudes to self

Psychological/somatic mindedness

Often there is an assumption that a clear dichotomy exists between the psychological and somatic perceptions of distress. In several cultures no such dichotomy exists. This is important to ascertain patients' ability to relate their symptoms in styles of communication allowing some help in treatment recommendations, and whether physical or psychological therapies will be acceptable. Too often, the label of somatization is applied in a derogatory manner. Although core depressive or psychotic symptoms are often regarded as universal, some see these constructs as disorders consistent with the developed world's conceptualization of distress and without universal applicability.

Previous experience of services and treatments

Such information is helpful in any psychiatric assessment of patients from other cultures, because previous bad experiences may deter patients from using the services optimally and engaging with them. Previous experiences may not necessarily have occurred in this country, and the criteria for help-seeking and service provisions may differ widely, thereby making the acceptability of statutory services problematic.

Racism

Members of ethnic minorities may have experienced discrimination in one or more fields of daily activities, such as legal, financial, educational, or health care activities. This may be full-blown open discriminatory experience, or suspected or perceived prejudicial treatment. This discriminatory behaviour could be on account of skin colour, religion, language, sex, race, sexual orientation, or other factors which may well be masked under a broader umbrella of feeling prejudiced. It is important to enquire about such events in a careful, paced, and sensitive manner so that the patient may respond accordingly. Even if perceived racist experiences do not directly contribute to the patient's presentation, these reports should be treated with respect and not dismissed as unimportant or irrelevant. If a patient finds that such experiences are not being understood or taken seriously, s/he may find it difficult to trust the clinician with more sensitive information. Anyone who has been exposed to these experiences directly or indirectly is understandably sensitive to repeated trauma of this kind and may interpret an unsatisfactory assessment and consultation as discriminatory.

Limitations of psychiatric assessments of cultural aspects

Duration, content, and focus of psychiatric assessment will depend very much upon the purpose of the assessment whether it is for diagnosis, management, rehabilitation, or psychotherapy.

It is better to use assessment interviews as the basis for beginning to understand a patient's distress and go on to develop a collaborative therapeutic relationship. Some patients, irrespective of their ethnic status, will require a longer assessment before a comprehensive management plan can be formulated so that it truly reflects the *optimal* package of interventions for that particular patient.

The inherent potential inadequacy of psychiatric assessment is amplified where the patient and the clinician come from different cultural backgrounds and for whom the only common reference point is the culture of the clinic.

Further reading

Bhugra, D. and Bhui, K. (2001). *Cross-cultural Psychiatry: A Practical Guide*. London: Arnold.

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Chapter 3

The psychiatric interview with children

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Some differences from interviewing adults

1. The child is *brought*: the reasons may not have been explained or they may be inaccurate. The child may believe s/he is going to be told off, taken away, kept, or hurt. They may be waiting for a blood test or operation.
2. The child is not the main informant.
3. The child may not answer any questions at all, no matter how experienced the psychiatrist. Sometimes children or even teenagers who will not speak can be persuaded to draw or play a game.

The experience of *uninterrupted* time with total attention from a sympathetic adult will be new to many children.

Setting

There are great advantages in ensuring that diagnostic interviews with children of similar age are broadly comparable. The interview room should be arranged so that only the objects which the psychiatrist considers will be needed are in view. The toys and games which are available need to be chosen with care so as to facilitate the types of observations which are of greatest diagnostic value. Observation of a child is much more difficult in a room cluttered with toys. For the child aged 6 or more it is usually preferable to spend most of the interview talking with him/her in the manner outlined below. With younger children and those with language or global delay there will need to be a greater reliance on non-verbal communication, and interaction will generally be easier if it occurs in a play situation.

With more mature children or adolescents the interview may often take more of the form of the adult psychiatric interview, but considerable modifications are still required since adults often come to the clinic because of their own concern over their problems. In contrast, the child or adolescent is generally referred because of someone else's concern.

General advice

1. Be non-judgemental.
2. Be prepared to specify limits—destruction and rage are not cathartic. 'That's not what people do here.' 'I want you to stop doing that.'
3. Avoid long silences which can become persecutory, particularly for adolescents. Some can be engaged in a game; some will respond to 'I wonder if …'.
4. Accept pictures if offered and keep them safely, because they will be asked about another time. Pictures should not be put in a place of honour on the wall; it will not be possible to do this for all the children who come and someone else may take them down.
5. Do not speak in an artificial voice; children are quite tone responsive.
6. Do not rush in with direct interpretations.

7. Do not let the child take toys out of the room. 'Sorry, these toys belong to the hospital and there would be none for you to play with if you took one home every time.'
8. Warn about the end of the session 5 minutes before it finishes.

Common errors

1. Avoiding relevant, but difficult, topics in pursuit of a pleasant experience for the child.
2. Siding with the child instead of displaying a constructive neutrality.
3. Leading a suggestible child into inappropriate answers.
4. Building castles in the air based on the nods of mute children.

Engagement

A short diagnostic family interview (10–15 minutes duration) provides a useful initial contact with the family. This can be followed by more formal history-taking, an individual interview with the child, and psychometric assessment as necessary. The clinician begins by explaining who s/he is (e.g. in the case of young children, 'I am a doctor who helps children and families with their problems and muddles') and the planned structure of the assessment. The family can then be asked to introduce themselves. Subsequently, it is helpful to ask the parents/carers if one may talk to the children first, and to engage the children individually on such (potentially) neutral topics as where they go to school and what that is like, whether they have friends, the names of their friends, what they like doing when at home or with friends, what they are good at. Having tried to engage all the children briefly in this way, it is important to explore with them why they think their parents decided that they should attend, preferably directing the question to a sibling of the referred child rather than to that child him/herself. The children are then encouraged to check with their parent(s) if their understanding regarding the reason for the appointment is correct. Exploration with the children regarding the reason for referral facilitates family communication around this issue, while at the same time clarifying the reasons for referral.

This joint time allows for the beginnings of an engagement with the children and family while observing family communication patterns, the emotional tone employed during communication (warm, critical, hostile, detached, understanding), and alliances between family members. Parents are generally pleased that time has been spent engaging their children in conversation and this time may act as a useful model for parents who have difficulty communicating with their child(ren).

Subsequent to the family interview, if co-workers are available, it is useful to split up so that one person can elicit a more formal history from the parents, while another can engage the child in an individual interview or more formal assessment. If siblings are present, they may be supervised by child-care staff (if available at the clinic) or an accompanying relative/family friend, or a parent may decide to monitor them while the other parent continues to participate in the assessment process. Information about the parent–child relationship can be gleaned from the parent(s) handling of the separation from the child and the child's response.

Children aged at least 6 years

Children will often be on the defensive, knowing that complaints have been made to the doctor about their behaviour. Therefore it is usually unwise to make any mention of the complaints at the beginning of the interview. The doctor should make it clear by the way s/he behaves towards the child that s/he is not acting as a judge or as someone who is going to correct or criticize. Rather, the aim is to show respect for the child as an individual and show interest in what s/he says and does.

If the child is expected to sit down for part of the interview, restless or uninhibited behaviour will be more readily observed. The first aim is to get him/her relaxed and talking freely, to assess the relationship s/he is able to form in such a setting, the level and lability of his/her mood, his/her conversation, and any habitual mannerisms. In order to provide an adequate sample of behaviour, there should be about 15 minutes of unstructured conversation. The child should be encouraged to talk about recent events and activities, what sort of things s/he like doing after school and at weekends, what s/he does with his/her friends and families, the names of his/her friends, the games s/he plays, what s/he enjoys and does not enjoy at school, etc. S/he may also be asked about his/her hopes for the future, and what s/he wants to do when s/he leaves school or is grown up.

Respond with interest, concern, or enthusiasm as may be appropriate (to set a relaxed and informal atmosphere, to try to elicit a range of emotions, and to assess the emotional responsiveness of the child and the kind of relationship s/he forms with the examiner). The interview must be geared to the child's age, intelligence, and interests. If the emotional responsiveness of the child is to be assessed adequately, it is necessary for the psychiatrist also to show a range of emotions (being more serious or concerned when asking about feelings of distress or worry, and more lively when responding to children's accounts of what interests or amuses them). Emotionally loaded topics should be pursued as they arise. The examiner's response should not block or lead away from expression of pathology or discomfort.

The child should then be questioned sympathetically about the specific information that should be elicited. Open questions are usually preferable and multiple choice questions are sometimes useful. Specific examples of relevant feelings or events should be asked for. Indirect statements ('I knew a boy once about your age who …') may be productive. (If the child accepts this convention there is no need to challenge it with statements such as 'This boy is you, isn't it?')

It is expedient to ease off topics that seem too threatening, but the interviewer should return to them. Does the child ever feel lonely, get into fights, get teased, or picked on? Is s/he picked on more than most other children? Why does s/he think s/he is picked on? Similarly, s/he should be asked how s/he gets on with his/her brothers and sisters. If s/he gets into fights, does s/he like fighting. Are they 'real' fights or 'friendly' fights?

The child should be asked specifically about worries, ruminations, fears, unhappiness, bad dreams, and the sorts of things that make him/her feel angry. For example, s/he might be asked, 'Most people tend to worry about some things. What kind of things do you worry about? Do you ever lie awake at night worrying about things? Do you ever get nasty thoughts on your mind that you cannot get rid of? Do you ever get fed up? Miserable? Cry? Feel really unhappy?' Suicidal thoughts should be pursued where appropriate. 'Are there things you are particularly afraid of? What about the dark? Spiders? Dogs? Monsters? Do you ever dream? What about bad dreams? Or have nightmares? What kind of things make you angry and annoyed?'

If anything positive should come up in answer to these questions, the psychiatrist should probe regarding the severity, frequency, and setting of the emotions (e.g. 'Do you ever feel so miserable that you want to go away and hide? Or that you want to run away? When was the last time that happened? How often do you feel like that? What sort of things make you fed up? Do you feel like that at home? at school etc.?').

Children can be very suggestible and will sometimes produce answers that they think the doctor wants. However, the anxious or depressed child can usually be distinguished by the affective state when talking about worries, fears, feeling fed up, etc. Although it is important to ask the child systematically about these issues, it is also necessary for much of the interview to consist of neutral or cheerful topics. Note whether the child spontaneously mentions worries or extends answers on those topics beyond the questions.

The child should be asked to draw a picture of someone or a house and everyone who lives in it, and encouraged to talk about it. This provides the opportunity to assess his/her natural skills, persistence, and distractibility, and also his/her attitudes and feelings, insofar as they are expressed in the drawing and what they say about the drawing. Handedness and fine motor skills can be assessed at the same time.

To assess attention span, persistence, and distractibility; children should be given some tasks within their ability but near to its limits. The drawing constitutes one task; in addition they might be asked to give the days of the week forwards and backwards and the months of the year, and also to do some simple arithmetic (such as serial 7s from 100, serial 3s from 30, and addition, subtraction, or multiplication tables). This is one situation in the interview where the child is stressed; emotionally loaded discussion is another. Tics and involuntary movements are often at their most apparent when the child is under stress, and should also be noted throughout the interview.

Note that **tics** are rapid, stereotyped, repetitive, non-rhythmic, predictable, and purposeless contractions of functionally related muscle groups, which can usually be imitated or suppressed voluntarily for a time, **stereotypies** are voluntary, repeated, isolated, identical, predictable, and often rhythmic actions, in which whole areas of the body are involved, and **mannerisms** are odd stylized embellishments of goal-directed movement.

Notice also whether the level of activity is increased: **restlessness** is an inability to remain in the seat appropriately, while **fidgetiness** refers to squirming in the seat or movements of parts of the body but not the whole child.

Children aged below 6 years

A play setting will usually be more appropriate for a child of 6 years or less; depending on the maturity of the child, it may sometimes be desirable to use a play interview with older children.

Games and toys should be chosen (1) to be suitable for the child's age, sex, and social background, (2) to provide an interaction with the interviewer, and (3) to encourage communication and imaginative play. The psychiatrist should become used to using a small range of toys (e.g. farm animals, colours, a doll's house with figures, plasticine). Board games like chess are not very productive. Imaginative games such as the squiggle game (making a drawing out of the child's squiggle and getting the child to do the same out of your squiggle), playing with family figures, etc. may offer the best opportunity for eliciting a range of behaviour and emotions. Where possible, the child should be seen without their parents. However, with very young children it may often be better to allow the mother to come in with the child first and then, after a short while, she can withdraw from the situation or leave the room.

It is important to allow the child to become used to the situation before the examiner makes an approach. Initially, it may be useful simply to let the child explore the room and the toys while the doctor makes a friendly remark or two and responds to the child's approaches, but makes no approach directly. The speed with which the child may be engaged in interaction and the way in which the approach is best made will vary considerably and must be judged in relation to each individual child. An attempt should be made to provide some activity known to interest the child.

The play situation should be utilized to make the same kind of assessment as with the older child, and, where appropriate, the child should be questioned in a manner suitable for his/her level of maturity. Young children cannot be expected to give descriptions of how they feel or to answer complex questions with long words about abstract concepts. Nevertheless, many can explain what they do at home, who they play with, etc.

Scheme for description of mental state

General description

Appearance, attractiveness, manner, style of dress, any evidence of neglect; response to separation from parents, entering the interview room, and the doctor's attempts to make contact.

The child's adjustment to the situation

Apprehension, appropriate or excessive reserve, emerging confidence, friendliness, disruption, and age appropriateness. Topics of spontaneous conversation.

Motor activity

- Amount of movement: reduced or increased
- Coordination
- Involuntary movements
- Posturing
- Rituals
- Hyperventilation

If any problems are noted, fuller neurological evaluation is needed.

Language

- Hearing: sounds, speech
- Comprehension
- Speech/vocalization/babble:
  - spontaneity
  - quantity, rate, and rhythm (e.g. stuttering)
  - pattern of intonation and stress
  - articulation (e.g. dysarthria)
  - grammatical accuracy and complexity
  - specific abnormalities (e.g. echoing, stereotyped features, I–you reversals, with written example if appropriate)
- Gesture: imitation/comprehension/use

If any problems are noted, go to p.56.

Social response to interviewer

- Social responsiveness to examiner's manner and comments (e.g. praise, reward)
- Rapport and eye contact: quality, quantity
- Reciprocity and empathy
- Social style (e.g. reserved, shy, expansive)
- Disinhibited, cheeky, precocious, teasing
- Negativistic, non-compliant, untruthful, surly
- Ingratiating, manipulative

If any problems are noted, go to p.56.

Affect

- Emotional expressiveness and range
- Happiness
- Anxiety: free-floating, situational, or specific phobias
- Panic attacks
- Observable tension
- Signs of autonomic disturbance
- Tearfulness

- Sadness, wretchedness, despair, apathy
- Thoughts of suicide or running away
- Shame, embarrassment, perplexity
- Anger, aggressiveness
- Irritability

Thought content

- Worries, fears
- Preoccupations, obsessions, suspicions
- Hopelessness, guilt.
- Low self-esteem, self-hatred
- Fantasies or wishes:
  - spontaneously mentioned
  - evoked (e.g. three wishes)
- Quality of ideation/play
- Abnormal beliefs or experiences

Cognition

- Attention span/distractibility
- Persistence
- Curiosity
- Orientation in time and space
- Memory

Attainment

Reading, spelling, and arithmetic are best assessed with standardized tests (e.g. Neale and Schonell for reading). If a formal assessment by a psychologist is not available, the child should be asked to read simple passages, to recall their gist, and to write a sentence about a previous event. The fluency, accuracy, and comprehension of reading are all important. This testing is even more necessary for children with disturbed behaviour or frustration in the classroom.

Standardized measures

An increasing number of rating scales for parents and teachers are available, and standardized structured or semistructured interviews are used for some clinical purposes.

The advantages of explicit and formalized interviewing schemes are that they ensure systematic cover of key parts, and can provide standards of whether a problem is severe enough to be deviant. A corresponding disadvantage is that they cannot cover everything. The crucial aspect of an individual case may be uncommon or even unique. Standardized schemes may divert attention away from the individually significant to what is common. They need to be supplemented with the general clinical enquiry that is described here. Most symptoms in child psychiatry are on a continuum with normality. The judgement of what constitutes a disorder should be based not only on the levels of symptoms, but also on an assessment of their impact on the child and the family.

Rating scales for parents and teachers are valuable as group tests, and sometimes for screening purposes. However, they are not yet sufficiently sensitive or specific for diagnosing an individual child. Rater effects, as well as the child's behaviour, will determine how they are completed.

Interviewer's subjective response to child

Conclusion

Finally, an opinion should be expressed on whether (and how) the child's mental state departs from the expected in relation to age, IQ, sex, and social background.

Sources of information

Children are usually referred as a result of adult concern about their behaviour. Much more reliance is placed on accounts derived from a variety of informants than is usual in adult psychiatry. One needs accounts of the child's behaviour and emotions at home, at school or at playgroup, and as observed during the assessment.

The child is continually developing. Symptoms and behaviour problems change with developmental stages, as do emotional needs. Even more than with adults, the assessment of behaviour and mental state needs to focus particularly on the aspects relevant to the individual child's developmental stage.

Children's social and personal development is strongly influenced by the relationships formed at home and at school. The attitudes of, and the quality of relationships with, adult care-givers need assessment as well as the child's development.

Interviewing parents

The history-taking consists of two aspects: (a) obtaining information about events and behaviour; (b) recording expressed feelings, emotions, or attitudes concerning these events or the individuals participating in them. Because much of the interview is concerned with eliciting precise factual material, it is important to establish early on that the interviewer is interested in feelings as well as events. Care should be taken to encourage positive and negative attitudes to an equal extent. Where the informant's feelings are in doubt, questions such as 'Does this kind of thing ever cause an atmosphere in the home?' or 'Does that ever make you feel on edge?' are also useful, but should be used sparingly. In assessing the informant's feelings and emotions, attention should be paid to the way things are said as well as to what is said. Differences in the tone of voice, shown in the speed, pitch, and intensity of speech, can be important in the recognition of emotions. Particular attention should be paid to expressed criticism, hostility, and warmth, and to whom it is directed. Facial expressions and gestures should also be taken into account.

It is desirable, when possible, to see both the mother and the father. The child's relationship with the father is as important as that with the mother, though its importance will be for somewhat different aspects of development. It is undesirable to have to rely only on a second-hand account of the father obtained from the mother. An interview with two parents together will often provide a good opportunity of observing parental interaction and relationships. If the parents are divorced or separated and the child spends time with each of them, it may be more appropriate to see the other parent on a separate occasion, as well as seeing any new significant adults in the family.

Present complaint

The interview with the parents begins with an enquiry about the problems or difficulties which are the chief cause of concern to the informant. The parents should tell their story in their own words and then be asked if there are any other difficulties. **Recent examples** of the problems should always be obtained as well as the **frequency** of the behaviour, its **severity**, and the **context** of its occurrence (e.g. at school or when the child is away from home). The circumstances which **antecede or precipitate** the behaviour and those which **ameliorate or aggravate** the difficulties should always be noted. Determine the time of onset of the difficulties and go back to the point in the child's development when his/her behaviour or emotions first appeared unusual, abnormal, or a cause for concern. Were there stresses at that time?

This part of the interview gives a good opportunity to assess parental feelings and attitudes, and their beliefs about the problem; and these should be carefully described. In addition, the interviewer should find out what strategies have been used to deal with the problem, and how much success or failure they have had with each method. It is also useful at this point to find out what effect the symptom has had on the rest of the family. If appropriate, the interviewer should also enquire what led to their seeking help with regard to the child's problem and why help has been sought now rather than at any other time.

If delayed or deviant development is prominent, whether global or specific, go to p.56 (the assessment of children with developmental disorders).

Systematic questioning

Review of other symptoms

Emotions

Are they happy or miserable? What makes them cry? Are they worried, depressed, suicidal, irritable, sulky? Do they show temper? Exhibit fears and panics? Are there tears on getting to school, or even school refusal? Are they fussy? Are there specific things or situations that arouse fear? Are there any compulsions to do things? (NB Obsessions and compulsions in children are not necessarily accompanied by a subjective sense of resistance and may present as a handicapping ritual that cannot be explained).

Antisocial trends

Are they disobedient? Destructive? Do they set fires? Tell lies? Steal? Are these problems only at home, or outside? Do they happen when solitary or with others? How are the problems dealt with? Has there been truanting or running away? Do they smoke, drink, sniff glue, or take drugs? Are they cruel to animals? Has there been any trouble with the police?

If the answer to any of these questions is 'yes', obtain details and enquire about the child's attitudes to discipline.

Activity and concentration

Are they overactive or restless? Will they stay still if expected to or are they always fidgety? How good is their concentration and what is the longest time they can concentrate on something interesting? Is there any change or loss of interest?

Eating, sleeping, and elimination

Are there eating difficulties at home or at school? Do they show food refusal or faddiness? Pica? Do they have sleeping difficulties: poor settling at night, waking in the night, nightmares? What are the sleeping arrangements? Is there enuresis: diurnal or nocturnal? Wetting when away from home? Have they ever been dry? Is there soiling or smearing? Have they ever been clean? Where is the lavatory? (Regularity of function is also a temperamental attribute.)

Current functioning

Typical day

A time budget helps to establish the context for children who are being assessed. In term time, who wakes up first? What happens? Who gets breakfast? How do the children behave first thing? How long do they take to get dressed? Who takes them to school? What are they like when they get home? What do they do then? How closely are they supervised? How do they behave during the evening meal; and when they are going to bed? What are the activities, and who provides care, during the school holidays? (NB This enquiry is essentially to establish the framework; do not spend a long time on meticulous recording of exact details.)

Peer relationships

Although poor peer relationships are not a specific disorder, they are a good indicator of general adjustment. What are the names of any friends? What do they do together? How close are they? How long have they been friends? Do they visit each other's houses? Do other children reject or ignore? Does the child seek social contact or prefer to be solitary? Are peer relationships only with a deviant group?

Sibling relationships

How do they get on? Is the child particularly attached to any siblings? How is this shown? Are there squabbles and with whom? Do they come to blows? Is there jealousy?

Relationships with adults

(This is also a convenient time to discover parental attitudes.) How does the child get on with mother/father? How is affection shown? Are they an easy child to get on with? How do they compare with other children? Whom do they take after and how? How do they get on with other adults? With teachers? Is there anyone they are particularly attached to? Does anyone help to look after them? What is it about them that parents find hardest to tolerate?

Family history and circumstances

Family structure, family life, and relationships

Make note of appearance, manner, and mental state of parental informant(s).

Persons in home

Obtain a list. It may be helpful to draw a family tree. Ask about age, religion, occupation, education, and health of each person. Have the child's parents been married before? Are they adopted or fostered? Mother's pregnancies, including miscarriages and stillbirths. Make sure biological parents are identified. Get the same details about a parent or siblings who live away from home.

For important people outside the home

Establish what contact there is and the child's relationship (e.g. grandparents and parental siblings). Obtain a sketch of the parent's own childhood.

Parental relationship

How do the parents get on with each other? What things do they enjoy doing together? How do they spend evenings and weekends? To what extent does the father participate in child care, discipline, and household tasks?

Parent–child interaction

What activities are done by parent and child jointly? Do they go out together? Play together? Help with homework? Help make things?

Child's participation in family activities

Does the child help with dressing, feeding, etc.? Who helps? Does the child help with washing up, shopping, errands, etc.?

Family patterns of relationships

Are they the mother's child or father's child? Do they confide in father or in mother? What attachments to other adults are there?

Rules at home

Do they have bedtime rules? Do they climb on furniture? Do they leave the house without saying where they are going, etc.? Are there restrictions on friends, staying out late, reading, or television? Who monitors the child's behaviour? Who reprimands? What method of punishment is used? Do they receive pocket money?

Family history of medical and mental health problems

A history of disorders in biological relatives needs to be taken carefully, because of the importance of genetic factors. For each first-degree relative one should question to determine the presence or absence of any psychiatric disorders, psychiatric treatment, depression, suicide, language delay, difficulty in learning to read, enuresis, social oddness, alcoholism, epilepsy, and court appearances. Age of onset is helpful. For the more extended family, establish not only which members of the family, if any, have had mental problems, but their exact position in the family, and the other members who have not had problems. If there is a familial disorder, the pattern of transmission needs to be established.

Home circumstances

A home visit is not done routinely, but when indicated it provides the best quality information and can often throw light on puzzling aspects of the history. Does the child live in a house or flat? How many rooms are there? Are there others in the home? What are the sleeping arrangements? Facilities (bath, lavatory, etc.)?

Other care arrangements

Does anyone else look after them: grandparents, baby-minder, neighbour after school, au pair, divorced parent at weekends, etc.?

Finances

What sources of finance are there? Are there any difficulties?

Neighbourhood

How long has the child lived there? Give a description of the area. Is it liked or disliked? Is there conflict with their neighbours? Is there any environmental threat (e.g. frequent assaults)?

Personal history

A general account of the art of eliciting a developmental history can be found on p.56 (the assessment of children with developmental disorders).

Pregnancy

Was it planned or not, and in what circumstances (e.g. adverse reaction of mother's own parents, abandoned by baby's father)? Were there complications such as toxaemia or haemorrhage, or stresses such as infection, smoking, alcohol, drugs, or X-rays?

Delivery

Enquire about the place of birth (home or hospital), length of labour, presentation, mode of delivery, maturity, birth-weight, complications? Was resuscitation given: incubator or Special Care Baby Unit? Give details of the mother's health during and after pregnancy, including depression.

Neonatal period

Were there difficulties breathing or sucking? Cyanotic attacks? Convulsions? Jaundice? Floppiness? Infection? Were they kept in hospital longer than usual?

Feeding and sleep pattern in infancy

Were they breast or bottle fed? When were they weaned? Were there difficulties? Normal sleep pattern? Describe any difficulties.

Social development in infancy

Were they placid or active? Irritable? What was their response to mother? Did they cry a lot? What other attachments did they have?

Milestones

Useful stages to ask about include sitting unsupported, walking unaided, first word with meaning, and first two-word phrases. Comparison with siblings' development is helpful when exact stages are not remembered. Currently, do they speak as well as others of the same age, or do they have difficulty in understanding or producing speech, or in pronunciation, such as a lisp, baby talk, or stutter? If there are marked difficulties, see Table 3.1. Do they show clumsiness? Is there preference for a particular hand and foot? Do they have any twitches? Where? Head-banging? Habits or rituals?

Bladder and bowel control

When were they dry by day and by night? (This is expected by the age of 5 years.) When did they have bowel control? (This is expected by the age of 4 years) Were there any difficulties? Was training used? If so, how was it done? Who trained: child-minders, nurseries, playgroups? How did they respond?

Illness and allergies

Were they ever in hospital: inpatient, outpatient, clinic, operations, accidents? Have they had any serious illnesses: measles, meningitis, encephalitis, fits, or convulsions? Are they off school at all? Do they suffer from asthma, headaches, stomach aches, or bilious attacks? How good is their sight and hearing? Do they suffer from fainting, fits, or absences? Any evidence of abnormal reactions to drugs or particular foods?

Separations

Have they ever been away from home without their parents or been separated while in hospital? Have they been apart from their parents for as long as 4 weeks? How were they looked after? What were the circumstances? How did they react?

Failures of care

Has there been any serious adversity in the past? Has caring been inadequate at any point (e.g. through illness, incapacity, or absence of a parent)? Has the child ever been maltreated (e.g. physical or sexual abuse)?

Schools

Which schools have they attended? How did they get on? Why were they changed? Has any teacher ever expressed concern to the parents? Has any statement of special education needs been made? Do they like the current school? Are progress reports satisfactory? Has the parent seen the child's teacher? (See section below on information from schools.)

Sex
Is there interest in the opposite sex? Has there yet been the development of menarche, body hair, and masturbation? Have they been instructed about sex, asked questions, or had any sexual experience? Is there any inappropriate sexual behaviour?

Strengths
What are the child's good qualities, abilities, and attractive attributes?

Temperamental or personality attributes

It is not easy to disentangle the child's premorbid characteristics from the present problems, but an attempt should be made. Some aspects of temperament are best shown in the response to new situations, new events, and new people, but attention should also be paid to the mode of functioning in routine situations.

Meeting new people
What is the child's behaviour with adults? With children? Do they approach strangers? Are they shy or clinging? How quickly do they adapt to someone new?

New situations
How do they react to new places, new gadgets, and new foods? Do they explore or hang back? How quick are they to adapt?

Emotional expression
How vigorous are they in expressing their feelings? Do they whimper or howl? Chuckle or roar with laughter? How happy/miserable were they before the present problems? How do they show their feelings?

Affection and relationships
Are they affectionate? Do they confide in anybody, and if so, who? What friendships have they formed?

Sensitivity
How do they respond to a person or animal being hurt? What is their reaction if they have done something wrong?

Information from school and other sources outside the family

Parental consent should always be obtained to contact any agency other than the referrer and the family doctor. In medico-legal work consent is needed to contact any agency other than the referrer. Permission to contact the school and other involved agencies can be requested when the first appointment is sent. If permission is not given for a key contact, such as that with the family doctor, it needs to be sought with detailed discussion and explanation of its importance.

A teacher's account of the child's behaviour at school is indispensable. Ask for information about:

- attendance
- academic strengths and weaknesses
- non-academic skills (e.g. art, music, woodwork, sports, etc.)
- behaviour in the classroom and playground
- social relationships with teachers and peers
- any other observations of importance.

For preschool children a report along the same lines from a nursery or playgroup leader is of similar importance. It can be helpful to have this information available at the first assessment.

It is good practice to explain to the family that a letter will be sent to the family doctor after the assessment and a request made to obtain old medical records etc. The family doctor frequently possesses further essential information. In medico-legal work the final report will be sent only to the referrer, who will then distribute it to the appropriate parties.

Psychological testing will usually be an important part of the systematic assessment of a child and will usually provide quantified information from behaviour and performance in a rigorously controlled setting. Such an assessment needs to be interpreted in the light of the validity of the test and the nature of the problem. A low test score from an uncooperative child should not necessarily be taken as implying a limitation of intellectual potential. A normal or high IQ score in a child with problems in everyday learning does not necessarily entail a non-cognitive explanation; there may be impairment in aspects of cognition that are not assessed by the tests used. If the clinical appraisal of cognitive functioning is discrepant with the psychometric evaluation, further enquiry is needed to find out why.

Synthesizing different sources

Evidence often conflicts. There is no single rule for how to resolve disagreements; clinical judgement is required.

When there is disagreement, first evaluate whether any of the sources is likely to be unreliable. Is the mother depressed and exaggerating psychopathology, or fearful of the consequences of the assessment and suppressing problems? Have the parents read accounts of disorders such as autism and presented a 'textbook' account? Does a teacher have insufficient acquaintance with the child to be accurate?

Next, consider whether disagreement comes from varying standards about what is expected from a child. Caregivers vary greatly in their beliefs about the degree of deviance that is required before they decide that a problem is present. It will not be enough to establish that a parent considers, for example, that their child is hyperactive. Rather, detailed enquiry will be needed to establish actual behaviours such as the length of time for which the child engages in constructive activities, and the time for which they can remain still in a situation where this is expected. Parents are often much better at recall of details of behaviour than at

judgement of what is the range of normality, and so apparent disagreements may disappear on close enquiry.

For some problems, priority should be given to one source of information. Children describe their depressed feelings more frequently than adults recognize them. Therefore the parental account may be insensitive, and the rule is often adopted that the symptom of depression is present if *any* informant gives a clear account of a marked problem in the child. In contrast, antisocial conduct may be denied by the child, especially if the parents are present, so that the parental account is often more sensitive.

For many problems, accounts may differ because the child is different in different situations. This specificity to context is in itself important diagnostic information. For example, hyperactivity that is pervasive across all sources of information is more likely to be based on neurodevelopmental dysfunction than the same behaviour that is seen only in one setting, such as school.

Finally, if doubt persists after careful enquiry and consideration of possible reasons, the best way of resolving disagreements is for the psychiatrist to make observations directly in the natural settings.

Assessment of children with developmental disorders

It is usually most convenient to begin with a chronological account of development. However, rather than go immediately to questions of pregnancy and delivery, it may be preferable to start by asking the parents when they first became concerned that something might be not quite right with the child's development, and what it was that aroused their concern at the time. Particularly with a first child, the parents' concern may have been aroused long after the child first showed delays or distortions in development. It is helpful to enquire whether, with hindsight, the parents think that all was well before they first became concerned and, if not, what it was that might have been abnormal. Having established the time and nature of those first indications of concern, it is generally easiest to go back to the time of pregnancy and work forwards systematically up to the present time. Most parents do not remember at all accurately when milestones occurred if they were within the normal range, but they are more likely to recall them if they were delayed. It is helpful to focus on that aspect first before going on to tie down the time more exactly. When seeking to date milestones, reference should be made to familiar landmarks rather than to ages as such. It might be appropriate, for example, to ask whether the child was walking on his first birthday, or when they moved house, or at the time of his first Christmas, or when the second child was born.

Particular attention needs to be paid to the developmental aspects of play, socialization, and language. With respect to the milestones of

language, it is crucial to be quite specific about what is being asked. Parents are very inclined to interpret all manner of sounds as speech, and especially as 'mama' and 'dada'. Consequently, it may be wise to ask very focused questions such as: 'When did he first use simple words with meaning, that is words other than mama and dada?' 'What were his first words?' 'How did he show that he knew their meaning?' In addition to the first use of single words, it is important to ask about babble, the use of two- or three-word phrases, the use of pointing, gesture, or mime, following instructions, and immediate or delayed echoing. It is helpful to identify some occasions that the parents remember reasonably clearly and then to focus on what the child was like at that time. In doing so, an attempt should be made to determine what the child was like at about 2 years, 30 months, 3 years, and 4 years.

Few parents think of socialization in terms of milestones or indeed in terms of specific behaviours. As a result, although the topic may be introduced by some general question such as 'How affectionate was he as a toddler?', it will always be necessary to proceed with a series of focused questions directed at eliciting information in key aspects of social relationships and social responsiveness at particular ages. Thus, for the 6–12 month age period it would be necessary to ask whether the child turned to look the parents directly in the face when they spoke to him/her, whether s/he put up his arms to be lifted, whether s/he nestled close when held, whether s/he protested when left, whether s/he laughed and chortled in response to parental overtures, whether s/he was comforted by being picked up and cuddled, and whether s/he was wary of strangers. Similarly with toddlers, questions should be asked about whether the child greeted a parent coming home, whether s/he sought to be cuddled when upset or hurt ('Did he come to you or did you have to go to him?'), whether s/he differentiated between parents and others to whom s/he went for comfort, whether s/he showed separation anxiety, and whether s/he could be playful and enter into the spirit of to-and-fro in a teasing or make-believing game.

Precise questions are required to elicit an adequate account of the child's play at particular ages. Thus, to determine whether play was normal at age 2 years, the clinician should ask about the child's use of toys and other objects. Did s/he recognize the appropriate use of miniature toys, such as pushing toy cars along the floor making car noises, or rather did s/he tend to spin the wheels, feel the texture of the paint, or listen to the sound of a wind-up car? Was there any pretend play, such as the use of toy tea sets, dolls, etc? Would the pretend play vary from day to day and would the pretend element be used to create any sort of sequence of story (with the toy cars racing each other, being parked in the garage, or being used to go to Granny's home)?

Having obtained a history of the development of play, social interaction, and language, with special reference to the first 5 years, it is necessary to obtain a comparably specific account of the child's **current behaviour** in these areas of functioning. Before proceeding to direct

questioning on particular features, it is helpful to gain an overall picture of the child's activities by asking how s/he spends his time on return from school or at a weekend. Such a description usually provides a life-like portrayal of the bleakness or richness of the child's inner and outer world, and focuses attention on the activities and experiences to be asked about in greater detail. For adequate evaluation to be possible, the specific questioning should be based on a systematic scheme that ensures that each of the crucial areas is covered, as set out in Tables 3.1–3.3.

Table 3.1 Scheme for current speech and language

1. Imitation	Of housework etc.
2. Inner language	Meaningful use of miniature objects, pretend play, drawing
3. Comprehension of gesture	
4. Comprehension of spoken language	
Hearing	Response to sounds; response to being called by name; reaction to loud noises; reaction to quiet meaningful sounds (mother's footsteps, noise of spoon in dish, food being prepared, door opening, rattle etc.); ever thought deaf?
Listening and attention	
Understanding	Response to simple and complicated instructions with and without gesture (obtain details of examples)
5. Vocalization and babble (non-speaking child)	
Amount	
Complexity	
Quality	
Social usage	Does s/he babble back to you?

6.	Language production	
	Mode	Gesture, pointing; taking by hand; speech
	Complexity	Syntactical and semantic; length of sentences; vocabulary; use of personal pronouns etc.
	Qualities	Echoing; stereotyped features; I–you confusion; made-up words; other oddities
	Amount	
	Use of social communication	Asking for things; to comment or chat to and fro; in reply to questions; mute in certain situations
7.	Word-sound production	Any difficulties in pronunciation; consonants omitted or substituted; which ones; slurring; dysarthria; nasality
		Are speech defects consistent or variable?
8.	Phonation and volume of speech	
9.	Prosody	Pattern of stress and tonal variation in speech
10.	Rhythm	
	Abnormalities	Stuttering; lack of cadence and inflection; coordination with breathing

Table 3.2 Scheme for current social interaction

1. Differentiation between people	Shown by different responses to mother, father, stranger, etc.
2. Selective attachment	
Source of security or comfort	To whom does s/he go when hurt?
Greeting	E.g. parent returning from work
Separation anxiety	
3. Social overtures	
Frequency and circumstances	
Appropriateness to the situation	
Quality	Visual gaze, facial expression; enthusiasm
4. Social responses	
Frequency and circumstances	
Quality	Eye-to-eye gaze, facial expression; emotions
Reciprocity	To-and-fro dialogue
5. Social play	
Playfulness	
Spontaneous imitation	
Cooperation and reciprocity, sharing	
Emotional expression	
Pleasure in the other person	
Humour	
Social excitement	

Table 3.3 Scheme for current play

1. Social aspects	See Table 3.1
2. Cognitive level	
Curiosity	
Understanding how things work	
Complexity	Puzzles; drawing; rule-following; inventiveness
Imagination	Pretend play; creativity; spontaneity; telling stories
3. Content, type, and quality	
Initiation	
Variable or stereotyped	
Unusual preoccupations	
Unusual object attachments	
Rituals and routines	
Resistance to change	
Stereotyped movements	
Interest in unusual aspects of people or objects	
4. Attention	
Orientation to a new situation and a new toy	
Distractibility to extraneous stimuli	
Length of time playing with each toy, and frequency of change of activity	
Persistence vs leaving play activities unfinished	
Acceptance of, and persistence with, toys or activities introduced by the examiner	

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Chapter 4

The mental state examination

Severe learning difficulties *64*
The mental state of adults *64*
The elderly *69*
Mild or moderate learning disability *70*

This chapter deals with the mental state examination of adults (this page), and also includes special points concerning examination of the elderly (p.69) and those with learning disability (pp.70–71). Special aspects of the examination (neuropsychiatric assessment of both adults and children; examination of those with epilepsy or catatonia, or who are mute or in a stupor) are considered in Chapter 5.

Severe learning difficulties

For people with mild or moderate learning disability, the normal mental state examination can be applied. However, severe disability is often accompanied by a major impairment of communication. Therefore it is necessary to eliminate pain or a physical illness as the precipitant of a behavioural crisis. The first sign of a developing physical or mental illness may be an exacerbation of pre-existing symptoms or behaviour. For example, at the onset of a mood disorder in an autistic person, there may initially be just an exaggeration of the autistic features. Pre-existing handicap (e.g. speech impediment) may mask the expression of typical mental symptoms. In this case, check for secondary symptoms, such as vegetative features (sleep, appetite, weight, etc.), when depression is suspected. The mental state may be difficult to define in detail, in which case the diagnosis must be based upon a balance of probabilities.

All clinical notes should be signed and dated.

The mental state of adults

The mental state examination elicits a snapshot of a patient's behavioural and psychological functioning. Its description should record information elicited by examination during the interview as well as other relevant observations (e.g. those made elsewhere in the clinic or hospital). There are three aspects to interviewing: obtaining information, observing the patient in a two-person interaction, and giving support.

One should always try to put the patient at ease, as only too frequently patients fail to mention crucial information through fear or anxiety. By doing this, benefits above and beyond the collection of clinical information can be gained. For example, a well-conducted interview provides a depressed or anxious patient with an opportunity to explain his/her problems to a doctor who, by asking about each symptom suffered, may be perceived to 'understand'. Therefore the mental state examination provides the interviewer with an opportunity to develop a therapeutic relationship further, and to offer empathy and support.

When describing the mental state of a patient, it is rarely useful to employ the terms 'normal' or 'abnormal' since these terms convey little. Instead, a description of the signs and symptoms elicited should be recorded under the headings listed below. This will enable others to form clinical judgements as to the significance of the information gathered, and will also be very useful for future reference.

Appearance and general behaviour

Few doctors are gifted with the descriptive talent of Charles Dickens, but a decent portrayal of a patient's appearance and behaviour is within the abilities of most. One should aim to give as complete, accurate, and lifelike a description as possible of how the patient appears and what can be observed in his/her behaviour.

Describe the patient's physical characteristics and his/her general behaviour. Is it appropriate, bizarre, incongruous, or agitated? How does s/he spend the day? Consider his/her personal self-care (cleanliness in general, hair, cosmetics, dress), eating, sleep, posture, and facial expression (depressed, elated, or anxious). Is s/he relaxed or tense and restless; slow, hesitant, or repetitive? How does s/he behave towards other patients, doctors, and nursing staff? Is s/he warm and open, or guarded, hostile, and threatening? Does s/he show good eye contact? Is s/he distractible or unresponsive? Does s/he appear frightened or frightening? Does s/he respond abnormally to external events? Can his/her attention be held and diverted?

Does s/he appear over-emotional (is s/he dancing and singing, or withdrawn, tearful, and sullen; wringing hands with anxiety or relaxed; preoccupied and perplexed, or does s/he show little emotional expression)? Does s/he appear to be responding to hallucinations? Does his/her behaviour suggest that s/he is disorientated? Specify orientation if doubtful. Do his/her movements and attitudes have an apparent purpose or meaning? Describe any motor abnormalities such as gestures, grimaces, tics, mannerisms, stereotypes, waxy flexibility, slowness, tremor, and rigidity. Is there much or little activity? Does it vary during the day, is it spontaneous, or how is it provoked? If s/he is inactive, does s/he resist passive movements, obey commands, or indicate awareness at all? A detailed account of the appearance and behaviour of catatonic, mute, or stuporose patients is especially valuable (these presentations are considered in detail in Chapter 5).

Speech

The **form** of the patient's utterances rather than their content is considered here. Does s/he say much or little, speak loudly or quietly, talk spontaneously or only in answer, slowly or quickly, hesitantly or promptly, to the point or wide of it, coherently, anxiously, discursively, loosely with interruptions, with sudden silences, with frequent changes of topic? Does s/he comment appropriately on events and things at hand, or does s/he use strange words or syntax, rhymes, puns, clang associations? How does the form of his/her talk vary with its subject? Is s/he monotonous or lyrical?

Verbatim samples of talk should be recorded so as to demonstrate any abnormalities such as flight of ideas, thought block, derailments of thought, incoherence or drivelling, reiterations, perseveration, neologisms, paraphasias, etc. Samples of what the patient actually said are more useful than your opinion as to whether, for example, s/he employed neologisms. Attach or include in the notes any examples of the patient's writing which appear abnormal.

Mood

The patient's appearance, motility, posture, and general behaviour as described above may give some indication of his/her mood. In addition, his/her answers to questions such as 'How do you feel in yourself?' 'What is your mood?' 'How about your spirits?' or similar enquiries should be recorded. Whenever depressive mood is suspected, specific enquiry should be made about the following: tearfulness, sadness, diurnal variation of mood, initial and middle insomnia, early morning wakening. Consider any suicidal ideas or plans, his/her attitude to the future, hopelessness, self-esteem, worthlessness, and guilt. Note any loss of appetite, weight, energy, motivation or libido, or constipation. Many variations of mood may be present, not merely happiness or sadness (e.g. such states as anxiety, fear, suspicion, or perplexity). Observe the constancy of the mood during the interview, those influences which change it, and the appropriateness of the patient's apparent emotional state to what s/he says. Note evidence of flatness or lability of affect, and specify any indications that the patient is concealing his/her true feelings.

Symptoms and behaviours associated with mania (elevated mood, little need for sleep or food, excessive energy, reckless behaviour, initiation of multiple tasks without completion, distractibility) and anxiety (tremor, dry mouth, butterflies, blurred vision, sweating) should also be evaluated and recorded here.

Thought content

The **content** of the patient's thoughts rather than their form is considered here. The patient's answers to questions such as 'What do you see as your main worries?' should be summarized. Are there any morbid thoughts, anxieties, or preoccupations regarding his/her past, present, and future? Do worries interfere with concentration or sleep? Are there any phobias or obsessional ruminations, compulsions, or rituals?

Abnormal thoughts should be comprehensively described and their precipitants, mode of onset, duration, intrusiveness, frequency, congruity with mood, fixity, and effect upon the patient's functioning noted. The description given should be full enough to allow future readers to make their own decision as to whether the patient suffered from, for example, a phobia, obsessional rumination/compulsion, overvalued idea, idea of reference, or delusion (including delusions of passivity and thought possession), all of which should be recorded within this section.

This section should always include an evaluation of any thoughts of **harm towards self or others**. Should such thoughts be admitted, a detailed account of the patient's intent should be recorded, including the onset, frequency, planning, preparation, and desire to harm. The patient should also be asked whether s/he believes that s/he is capable of realizing these thoughts, and if there are any factors that are preventing him/her from completing the act.

Abnormal beliefs and interpretations of events

Specify the content, mode of onset and degree of fixity of any unusual or abnormal beliefs.

1. In relation to the environment (e.g. ideas of reference, misinterpretations, or delusions); beliefs that s/he is being persecuted, that s/he is being treated in a special way, or is the subject of an experiment.
2. In relation to the body (e.g. ideas or delusions of bodily change).
3. In relation to the self (e.g. delusions of passivity, influence, thought reading, or intrusion).

Abnormal experiences referred to environment, body, or self

Abnormalities in perception should be recorded here.

1. Environment: hallucinations or illusions (auditory, visual, olfactory, gustatory, or tactile) as well as feelings of familiarity or unfamiliarity, derealization, or déjà-vu.
2. Body: feelings of deadness, pain, or other alterations of bodily sensation; somatic hallucinations.
3. Self: depersonalization; awareness of disturbance in mechanism of thinking, blocking, retardation, autochthonous ideas, etc.

The source, content, vividness, reality, duration, and other characteristics of these experiences should be recorded, together with the time of occurrence (e.g. at night, when alone, when falling asleep, or on awakening). Ascertain exacerbating or ameliorating factors as well as the patient's insight into the cause, in addition to the significance and emotional impact, of any perceptual abnormality.

The cognitive state

This should be briefly assessed in every patient and related to his/her premorbid intelligence (see p.77). For younger patients who are not suspected of cerebral organic disease, the tests mentioned below for orientation, attention, concentration, and memory should be administered. For older patients, see the section on assessment of the elderly patient (p.148). When cognitive impairment or cerebral disease is suspected, further tests will need to be given from the schema for further examination of patients with suspected organic cerebral disease (Chapter 5).

Orientation

If there is any reason to doubt the patient's orientation, record the patient's answers to questions about his/her own name and identity, the place where s/he is, the time of day, and the date.

Attention and concentration

Is his/her attention easily aroused and sustained? Does s/he concentrate? Is s/he easily distracted? To test his/her concentration and attention, ask him/her to tell the days or the months in reverse order, or to do simple arithmetical problems requiring 'carrying over' (e.g. 112–25) or

subtraction of serial 7s from 100 (give answers and time taken). Give digits to repeat forwards, and then others to repeat backwards (delivered evenly and at 1-second intervals) and record how many s/he can reproduce in each direction.

Memory

In all cases memory should be assessed by comparing the patient's account of his/her life with that given by others, and by examining his/her account for intrinsic evidence of gaps or inconsistencies. Special attention should be paid to memory for recent events, such as those of his/her admission to hospital and happenings in the ward since then. Where there is selective impairment of memory for special incidents, periods, or recent or remote happenings, this should be recorded in detail, and the patient's attitude to his/her forgetfulness and the things forgotten particularly investigated. Record any evidence of confabulation or false memories. If the patient confabulates, is this spontaneous or in response to suggestion only? Retrograde and anterograde amnesia must be specified in detail in relation to head injury or epileptic phenomena.

Intelligence

The patient's expected intelligence should be gauged from his/her history, general knowledge, and educational and occupational record. Where this is unknown, simple tests for general information and grasp should be given, and an assessment made of his/her experience and interests. An indirect measure of intelligence may also be obtained from assessing the patient's scholastic achievements by testing his/her reading, spelling, and arithmetical abilities. A more objective measure can be obtained by using the Mill Hill and Progressive Matrices Tests from which an intelligence quotient (IQ) can be derived. Disorder should be suspected if a discrepancy is found between the results of these tests and the level of intelligence anticipated by assessing the patient's literacy and numeracy, or if performance measures are markedly inferior to verbal measures.

Patient's appraisal of illness, difficulties and prospects

What is the patient's attitude to his/her present state? Does s/he regard it as an illness, as 'physical', 'mental', or 'nervous', or as needing treatment? What does s/he attribute it to? Is s/he aware of any mistakes s/he made spontaneously or in response to tests? How does s/he regard them and other details of his/her condition? How does s/he regard previous experiences, mental illnesses, etc.? Can s/he appreciate possible connections between his/her illness and stressful life situations, spontaneously or when suggested? Are his/her attitudes constructive or unconstructive, realistic or unrealistic? Is his/her judgement good when discussing financial or domestic problems etc.? What does s/he propose to do when s/he has left the hospital or clinic? What is his/her attitude to supervision and care?

The interviewer's reaction to the patient

If it is appropriate, a brief account may be given of the way in which the interviewer is affected by the patient's behaviour. Did the patient arouse sympathy, concern, sadness, anxiety, irritation, frustration, impatience, or anger?

The elderly

Most older people have no objections to cognitive assessment when it is introduced with tact. It is helpful to start off by asking whether the patient has experienced any problems with memory and concentration (and, if so, whether this has bothered them and what sort of things they find that they forget). After this, the cognitive assessment may make more sense. A useful preamble is as follows: 'I am going to ask a few questions about memory and concentration. Some of these may seem very easy and others might be quite difficult but we need to ask everyone the same questions.'

Some patients with dementia are unwilling to undergo formal testing and respond with irritation, unexplained refusal, or bland replies such as 'I don't pay attention to that sort of thing'. Such replies may be an attempt to camouflage an impairment and should be handled with tact. A reliable collateral history is invaluable in these situations.

Where the patient agrees to formal testing, a short cognitive screening test such as the Mini-Mental State Examination (MMSE) or the Abbreviated Mental Test (AMT) can be used (see Appendix 2). The MMSE can give an approximate idea of the severity of impairment in dementia, while a high score may provide evidence against substantial cognitive impairment. It may also be helpful in future assessments to have an idea of previous function, and therefore it is important that previous assessments are obtained wherever possible so as to put any current score in context.

Interpreting the scores on the AMT and the MMSE

The tests are described in Appendix 2. It is vital to take previous education, levels of literacy, and sensory deficits into account when interpreting scores from these screening tests. For example, someone with high educational attainment may have clinically evident dementia and still achieve a maximum score on the MMSE. Unfortunately, both screening tests have poor cross-cultural validity and results should be interpreted with appropriate caution.

Scores of 6 or below on the AMT indicate possible dementia, and the need for a more formal assessment (unless the test is being used in primary care to assess progress in a patient with known dementia).

The MMSE was developed at Johns Hopkins University for use in neurological patients but has since been validated in a wide variety of settings. A score of 23 or less is indicative of 'dementia'. The MMSE is sensitive to the effects of age, educational background, and socio-economic status. For

patients aged over 70 years who left school before 15, the cut-point should be reduced by 3 points.

Cognitive screening tests such as the MMSE provide relatively little information concerning specific cognitive deficits such as impairment of memory or frontal lobe function. If cognitive impairment is suspected a formal assessment should be carried out as outlined in Chapter 5.

Mood state

Some elderly patients with profound depression deny depressed mood but show other prominent symptoms such as anxiety, somatic or dissociative symptoms, or cognitive impairment.

Psychotic and behavioural problems

These are best elicited from an informant.

Physical examination

Many elderly patients suffer from concurrent physical illness, and a thorough physical examination should always be carried out. Special attention should be given to any signs of physical trauma, possibly occurring as a result of abuse.

Environment

If the patient is being assessed at home, some inspection of the home circumstances should be made. This is an important part of evaluating the degree of risk posed to the patient (and possibly others). Remember that self-neglect is not diagnostic of any particular disorder and can occur in severe functional illness as well as dementia.

- Is the dwelling in a good state of repair and decoration?
- Is it secure?
- Are gas, electricity, and water connected?
- Is there adequate heating and lighting?
- Is the gas ever left on unlit?
- Is there evidence of the careless use of lighted cigarettes?
- Is the patient able to call for help if necessary (e.g. via a centralized alarm system)?
- Is there enough food in the home to make, at least, small snacks/hot drinks?
- Is there evidence of urinary or faecal incontinence?
- Are any pets well cared for?

Mild or moderate learning disability

By definition, a learning-disabled person will have a degree of developmental delay. Detailed examination of the mental state is critical. This is not easy but much information can be gained by observation.

Mood disorders and psychoses may present initially as behavioural changes, for example overactivity in hypomania or social withdrawal in depression.

Autistically disabled people usually become more inaccessible when depressed; they present as 'more autistic'.

Abnormal mental phenomena may be expressed in a fleeting and fragmentary manner; sustained observation is often necessary to allow any abnormalities to emerge. Do not waste time looking for specific syndromes.

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Chapter 5

Neuropsychiatric assessment

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History

The history gives a longitudinal view of the patient's condition and usually provides the diagnosis; examination should be considered confirmatory. A minority of cases may give misleading presentations, especially in the early stages or where there is an abundance of non-organic features (i.e. in psychotic, conversion, or factitious disorders). The time course of the disorder is most helpful in aiding diagnosis; focus on the mode of onset (and antecedent conditions) and the progression (duration and fluctuations).

Presenting complaint (Table 5.1)

When was change first noticed? Who noticed it first? How did it affect daily function? What was the reason for presentation to medical services? What was the effect of any intervention at that stage? Any precipitating or relieving factors?

Collateral history from an informant is crucial in confirming onset and course of the disorder, particularly when there is suspicion of cognitive impairment or clouding of consciousness. This means discussions with family, friends, and work colleagues, as well as professional staff who have had contact with the patient.

Family history

Any fits, memory problems, dementia, or other neurological disorder?

Personal history

- Obstetric complications?
- Delayed walking/talking or other milestones?
- Any learning difficulties?
- Educational attainment?
- Performance decline at work?
- Any occupational hazards (e.g. lead or solvents)?
- Amount, frequency, mode of administration (e.g. intravenous) of recreational drugs consumed, including alcohol; pattern of consumption over time.

Table 5.1 Time course and diagnosis of neuropsychiatric disorder

Rapid decline and complete recovery	Transient ischaemic attack, epilepsy, transient global amnesia
Slow steady decline	Alzheimer's disease, Huntington's disease, Parkinson's disease, normal pressure hydrocephalus
Rapid steady decline	Encephalitis, brain tumour, raised intracranial pressure, cerebral abscess
Stepwise deterioration	Vascular dementia, multiple sclerosis
Diurnal variation	Myasthenia gravis
Static condition	Autism, Asperger's syndrome, cerebral palsy

Table 5.2 Organic disorders and their neuropsychiatric sequelae

Epilepsy	Postictal/ictal/interictal psychosis, Todd's paresis
Head injury	Acute/chronic subdural, alcohol abuse
Connective tissue disease	Dementia, depression, psychosis
Thyroid disease	Anxiety, depression, dementia
Diabetes	Hypoglycaemic episodes, cerebrovascular events, dementia
Cardiovascular disease	Hypoxic delirium, sleep apnoea
Surgery/anaesthetic	Cognitive impairment from hypoxic episodes
Sepsis	Brain abscess
Menstrual disturbance	Pituitary adenoma
Urinary incontinence	Frontal syndrome, normal pressure hydrocephalus

Table 5.3 Drugs contributing to neuropsychiatric disorder

Neuroleptics (except clozapine), antiemetics	Movement disorders
Lithium	Tremor, confusion, ataxia
Neuroleptics	Neuroleptic malignant syndrome (hyperthermia, rigidity, autonomic lability, decreased consciousness)
SSRIs, MAOIs, TCAs, lithium	Serotonin syndrome (restlessness, altered mental state, hyper-reflexia, tremor, fits, rigors, myoclonus)
Amphetamines, appetite suppressants	Anxiety, insomnia, psychosis
Steroids	Confusion, depression, psychosis
Benzodiazepines	Dependence, confusional state, ataxia, withdrawal syndrome
Amphetamines, cocaine, LSD	Psychosis
Alcohol	Dependence, withdrawal syndrome, Wernicke–Korsakoff syndrome, ataxia, peripheral neuropathy, decreased consciousness, dementia, head injury (acute/chronic subdural)
Anti-epileptics	Confusion, ataxia, psychosis (especially vigabatrin)

SSRI, selective serotonin reuptake inhibitor; MAOI, monoamine oxidase inhibitor, TCA, tricyclic antidepressant.

Previous medical history (Table 5.2)

- Any childhood infections, fits, or head injury?
- If any loss of consciousness, how long, and what memory blanks before and after?
- Ever seen a neurologist or physician?

Prescribed medication (Table 5.3)

Has the patient suffered any side effects?

Mental state examination

This begins when the patient enters the room and provides a cross-sectional view of his/her condition. Do not hurry the patient and note the degree of cooperation. If cognitive impairment seems present, move to a full cognitive examination rather than struggle to obtain the history. If there is an apparent decreased level of consciousness, use the Glasgow Coma Scale (best verbal and motor responses, and pupillary reflex) to monitor this.

Cognitive examination

Keep in mind premorbid intelligence.

Orientation

Disorientation is a key indication of cerebral dysfunction, reflecting alterations in the level of consciousness. Time disorientation is regarded as the hallmark of acute organic reactions.

- Time/place/person: does the patient know who they are, where they are, and what the date is?

Attention and concentration

These test alertness and the capacity to control information processing in the brain. Along with tests for orientation, these are a means of evaluating the patient's level of conscious awareness.

- Reciting backwards: for example, give reverse days of the week or spell WORLD backwards.
- Serial 7s: counting down from 100 in subtractions of 7.
- Digit span recall—forwards and backwards: remember to deliver each digit in a monotone 1 second apart (average seven forward).

Language ability

Dysarthria, a difficulty in the mechanical production of speech, should be assessed before **dysphasia**, which is the cortical partial failure of language function. **Receptive dysphasia** can be detected by asking the patient to point to surrounding objects, or to respond to a short series of verbal commands. You can test for **expressive dysphasia** by asking the patient to name everyday objects **(nominal dysphasia)** or write a sentence of his/her own choice. Do not forget to check handedness as 95 per cent of right-handers and the majority of left-handers have relative language dominance in the left hemisphere.

- **Repetition**
  - 'West Register Street' and 'no ifs, ands, or buts'

This tests for dysarthria and the intactness of the connections between the input and output of speech.

- **Comprehension**
  - Response to simple instructions:
    — point correctly on command (e.g. surrounding objects)
    — carry out simple orders on request (e.g. pick up an object, show tongue).
  - Response to complex instructions:
    — tear paper into three pieces (Marie's three-paper test).
- **Word finding**
  - Name both common and uncommon objects (e.g. parts of a wrist watch and other objects in the room).

This tests for nominal dysphasia (the reduced capacity to retrieve words used in everyday speech), which may be the only language disturbance. Note circumlocutions used to cover this deficit.

- **Reading**
  - Observe for content errors (also dysarthria and dysprosody).
- **Writing**
  - Test ability to write spontaneously and examine written productions for substitutions, perseverations, spelling errors, and letter reversals. Note that asking a patient to write something about what they have just read (e.g. a news item) also further tests their comprehension.

Memory

Amnesia (acquired memory dysfunction) is an abnormality of registering, storing, recalling, or recognizing information and events. **Focal amnestic states** can occur with relative preservation of other cognitive functions which contrasts with **diffuse amnesic states**. All are qualitatively different from **psychogenic amnesias**. Memory failure is a particularly sensitive indicator of cerebral dysfunction. Your patient may have deficits in explicit memory, with difficulty in conscious recollection, yet retain implicit (procedural/skills) knowledge. For example, they may be able to find their way around familiar surroundings but be unable to recollect (describe) their route.

- **Immediate memory span (or 'ultra-short-term memory')**
  - Digit repetition (tested previously)
- **Recent events**
  - Recall of the temporal sequence of events (e.g. the events of the interview so far)
- **New learning**
- **Name and address**
  - Ask for immediate reproduction (testing **registration**) and record the answer verbatim (repeat if necessary). If one or more mistakes are made, the entire name and address should be provided again.
  - Test **retrieval** 3–5 minutes later after interposing other cognitive tests, and again record the answer verbatim.

Table 5.4 Features of parietal lobe dysfunction

Dominant	
Dysphasia	Receptive dysphasia
Gerstmann's syndrome[a]	Finger agnosia, dyscalculia, right–left disorientation, agraphia
Non-dominant	
Topographical disorientation[b]	Getting lost, inability to learn new routes
Agnosias	Visuospatial agnosia (inability to recognize from visually presented information)[b]
	Prosopagnosia (inability to recognize faces) (associated with posterior lesion)
Apraxias	Constructional apraxia (difficulty in copying a visually presented model, e.g. 3D cube)[b]
Body image disorder	Anosognosia (failure to recognize a disabled limb)[b]
	Neglect (patient pays no attention to one side, e.g. shaving one side of face, drawing clock with only half the face represented)[b]

[a] More often seen in multiple choice questionnaires than clinically.
[b] Not very well lateralized, but deficits more common and severe with right hemisphere damage.

Table 5.5 Associated neurological deficit with parietal lesions

Optic radiation	Homonymous lower quadrantanopia[a]
Sensory cortex	Contralateral disturbance, e.g. astereognosis, reduced discrimination
Perceptual rivalry	Visual and sensory inattention

[a] Posterior lesion.

- **Recall (paired association): free and cued**
  - Give patient a list of six to ten paired items (e.g. colour—blue, flower—daffodil, etc.) or use a simpler test of three-word recall, with each word being categorically different (e.g. car, river, monkey)

Giving verbal cues when spontaneous recall fails tests storage. A retrieval deficit is suggested if the patient's performance improves. Information processing is also being tested, as thinking of semantic links facilitates recall. These tests are especially valuable with anxious or disturbed patients.

- **Babcock sentence**
  - Ask the patient to repeat a sentence appropriate to their intellectual level, e.g.
    - — Dull (50 per cent of 11-year-olds): 'Yesterday we went for a ride in our car along the road that crosses the bridge.'
    - — Dull–average (50 per cent of 13-year-olds): 'The aeroplane made a careful landing in the space that had been prepared for it.'
    - — Average (50 per cent of 15-year-olds): 'The redheaded woodpeckers made a terrible fuss as they tried to drive the young away from the nest.'
    - — Superior intelligence: 'One thing a nation needs to become rich and great is a large secure supply of wood.'

Test the number of repetitions necessary for accurate reproduction. (Three repetitions of a sentence such as this should allow word-perfect reproduction.)

- **General information**
  - Semantic (conceptual) memory (e.g. names of key personalities, well-known dates, places and events both distant and current)
  - Episodic (personal) memory: matters unique to the individual (e.g. name of examiner, what the examiner has asked since the interview began).
  - Non-verbal memory should be assessed by asking the patient to reproduce a simple figure, such as a cross or a clock face showing a specific time, after a 5-minute interval. Initial copying of the figure tests **constructional praxis** (see below) as well as registration.

Apraxia

Apraxia is the inability to perform a volitional act even though the peripheral motor system and sensorium are intact. It is rarely seen without dysphasia, except in the case of constructional dyspraxia:

- ability to imitate postures and make-believe movements (e.g. wave goodbye)
- ask the patient to perform a complex coordinated sequence of actions (e.g. fold a letter and put it in an envelope).

Ideomotor apraxia is the inability to carry out simple coordinated movement sequences on command, despite being able to carry out these actions spontaneously. **Ideational apraxia** is the inability to carry out a planned complex coordinated sequence, despite demonstrating an ability to carry out each individual component. **Constructional apraxia** has been tested by the drawing above. **Dressing apraxia** (said to be a non-dominant parietal lobe problem) is evident from the informant or by asking the patient to dress. **Gait apraxia** is assessed by the tandem gait test (see below).

Agnosias

Agnosias are rare and complex disorders of perceptual recognition. The individual is unable to understand the significance of sensory stimuli even though the sensory pathways and sensorium are intact. All modalities may be affected but visuospatial problems are more common.

Table 5.6 Features of temporal lobe dysfunction

Dominant	
Receptive dysphasia	Language comprehension affected[b]; includes alexia and agraphia in posterior lesions
Amnesic syndromes	Especially for verbal material
Non-dominant	
Visuospatial deficits[a]	E.g. objects (visual agnosia) and face recognition (prosopagnosia)
Amusia	Difficulty with melody, cadence, and emotional content of music
Amnesic syndromes	Especially for non-verbal material

[a]Not well lateralized, but deficits more common and severe with right hemisphere damage.
[b]Superior dominant

Table 5.7 Associated neurological deficits with temporal lobe lesions

Auditory cortex	Cortical deafness
Optic radiation	Homonymous upper quadrantanopia
Bilateral medial temporal lobe (involving hippocampus)	Amnesic syndromes, global amnesia with normal immediate recall
Limbic system	Personality change (associated with decreased intellect), depersonalization, emotional instability, aggressive or antisocial behaviour

Visuospatial function

Tests are as follows.

- Distance estimation between objects: tests proportions
- Copy a diagram: tests constructional ability
- Freehand drawing (e.g. drawing a clock face with numbers)
- Ability to describe an object and explain what it is

Visuospatial agnosia (broadly synonymous with constructional apraxia) and **hemineglect** will be shown by omissions in images copied. **Visual object agnosia** (visual recognition failure) is present when the patient fails to identify objects by sight and fails to name them, i.e. they are unable to grasp the meaning of the object purely by looking at it (but can through other senses). **Astereognosia** is the failure to identify three-dimensional form and is tested by placing a familiar object (e.g. a key) in the patient's hand. **Agraphognosia** or **agraphaesthesia** is detected by tracing numbers on the palms with a retracted ball-pen which the patient then fails to recognize.

Frontal lobe function

Evidence of frontal lobe damage would have been suggested by a history of behavioural disturbance, personality change, and 'executive dysfunction' (e.g. disturbance to planning and monitoring goal-directed behaviours).

Tests are as follows (the validity and reiability of these tests are not beyond dispute).

- Verbal fluency: ability to generate categorical lists, e.g. words beginning with the letter F (FAS test: 10 words per letter in 1 minute is the average).
- Motor sequencing (Luria's fist-edge-palm test): this should be assessed by first demonstrating the sequence to the patient and then asking him/her to continue the imitation for at least 30 seconds. Remember to vary the sequence between left and right hands to avoid a learning effect, and that anxiety is the most common cause of errors. Observe for motor perseveration.
- Abstract thinking and conceptualization: proverbs (e.g. 'People in glass houses shouldn't throw stones'); difference between concepts (e.g. child and dwarf).
- Cognitive estimates test (e.g. largest object in a household room).

Occipital lobe lesions

These can lead to simple or complex visual hallucinations, as well as difficulties with visual recognition.

Table 5.8 Features of frontal lobe dysfunction

Social behaviour	Disinhibition, distractability, slowed psychomotor activity[a]
Motivation, planning and initiating	Lack of drive[a], poor goal setting and learning
Organizing and problem solving	Errors of judgement, failure to anticipate, perseveration[a]
Adapting and shifting attention	Catastrophic response, inability to adapt to the unexpected[a]
Personality change[b]	Over-familiarity, tactlessness, empty fatuous euphoria[a], sexual indiscretion

[a] Characteristics which help differentiate from mania.
[b] Two subtypes are described: 'pseudodepressive' (akinesia) (lateral frontal) and 'pseudopsychopathic' (disinhibition) (medial orbital).

Table 5.9 Associated neurological deficit with frontal lesions

Broca's area	Expressive dysphasia, if dominant hemisphere
Precentral gyrus motor complex	Contralateral hemiplegia
Supplementary motor area	Paralysis of head and eye movement (head and eyes turn towards diseased side) present only in the acute stage of a lesion; compensation occurs after a few days
Paracentral lobule	Bowel and bladder dysfunction
Optic nerve	Ipsilateral optic atrophy (when associated with contralateral papilloedema = (Foster–Kennedy syndrome))
Olfactory nerve	Anosmia

Table 5.10 Other less common frontal lobe tests

Primitive reflexes	
Grasp	Grasping of the contralateral hand on stroking the palm from the radial to ulnar side
Pout	Pouting of the lips, elicited by either stroking down the filtrum or by gently tapping on a spatula placed over the lips
Palmo-mental	A 'wince' on stroking the ipsilateral thenar eminence
Alternate tapping	Ability to understand a simple tapped code and adapt when told that the rules have changed (e.g. ABABAB–AABBAABB)
Perseveration	Motor or verbal; inability to avoid repeating the last given action or word
Reciprocal coordination	Ability to use both hands simultaneously, smoothly, and quickly without example

Corpus callosal lesions

These can lead to callosal disconnection syndromes and severe and rapid intellectual deterioration (anterior).

Diencephalic and brainstem lesions

These can lead to Korsakoff-type amnesia (especially deep midline), rapidly progressive dementia with intellectual deterioration secondary to hydrocephalus, frontal-type syndrome (with better insight), hypersomnia, emotional lability, stupor, akinetic mutism, pseudobulbar palsy, and hypothalamic disorders.

Neurological examination

The examination does not have to be arduous for either the doctor or the patient. A recommended neuropsychiatric screen, which is preferable to a formal head-to-toe neurological examination, is given below. Note **handedness** by watching the patient write; right–left discrimination has already been assessed (see ideomotor apraxia). **Gait** is a good way of testing voluntary movement. Ask the patient to walk placing one foot in front of the other, as though on a tightrope (**tandem gait test**). **Sitting** or other resting posture allows observation of involuntary movements

Reflexes can be quickly tested with a tendon hammer once the patient is sitting or recumbent. Hyper-reflexic tendon jerks are most commonly due to anxiety. An upgoing (positive) plantar or Babinski reflex indicates an upper motor neuron lesion. The primitive reflexes are described in Table 5.10.

Testing of **power** and **sensation** may be performed if the history indicates a deficit. Peripheral neuropathy is probably the most common positive finding, and may be due to diabetes, alcohol, or lead poisoning.

Further reading

Kopelman M.D. (1994) Structured psychiatric interview: assessment of the cognitive state. *British Journal of Hospital Medicine*, **52**, 277–81.

Table 5.11 Assessing stance and gait

Deficit	Appearance	Confirmatory signs	Neuropsychiatric associations
Hemiplegic	Arm and hand flexed and internally rotated	Increased tone, brisk reflexes, upgoing plantar	Depression is common post-CVA (especially in anterior lesions?) Hemiplegias acquired in childhood may lead to preserved language function at the expense of visuospatial skills, regardless of lesion site
Parkinsonian	Stooped posture, reduced arm swing, bradykinesia, shuffling gait which improves with afferent input (e.g. walking with a friend)	'Lead-pipe' rigidity, 'pill-rolling' tremor which combine to give 'cogwheeling' Paucity of speech and facial expression	Drug-induced (where tremor uncommon) seen more than PD Personality change (obsessionality and hypochondriasis) said to characterize PD Dementia: 10%–15% Depression common but unrelated to stage of disease; psychosis usually iatrogenic
Cerebellar	Wide-based stance and gait, slurred speech	Dysmetria (past pointing), intention tremor, nystagmus	Possible current intoxication (alcohol, lithium, anticonvulsants) or chronic damage (e.g. MS; look for pale disks, pyramidal signs) or alcoholism
Akathisia	Motor restlessness, inability to sit or stand still	Subjective sense of inner distress and motor tension	Present in 20%–30% of patients on neuroleptics; often overlooked

CVA, cerebrovascular accident; PD, Parkinson's disease; MS, multiple sclerosis.

Table 5.12 Assessing abnormal movements

Deficit	Appearance	Confirmatory signs	Neuropsychiatric associations
Choreiform	Rapid irregular dance-like or jerky involuntary movements	Consider more detailed cognitive testing	Accompanying medical condition (e.g. SLE, pregnancy, thyrotoxicosis) Drug-induced OCP, neuroleptics, phenytoin Basal ganglia vascular disease, neuroacanthocytosis, Huntington's disease
Tic disorders	Repeated jerky movements, mimicking normal actions and under some voluntary control	Ask about suppressibility, and OCP	Common in children but reduce with age; usually affect periocular muscles, face, neck, and shoulders Gilles de la Tourette syndrome begins with simple tics, progressing to jumps, genuflexions, and hops; vocal tics and coprolalia also seen later
Dystonic	Sustained muscular contractions cause repetitive twisting movements, or abnormal postures and bizarre gaits; may occur focally (e.g. writer's cramp, spasmodic torticollis	Recheck medication history: neuroleptics, antiemetics, SSRIs, and lithium have been implicated	Acute dystonia rapidly relieved by anticholinergics Tardive dystonia is difficult to treat and can be very disabling Rarer causes include Wilson's disease (look for associated basal ganglia and liver disease) and Huntington's disease

SLE, systemic lupus erythametosus; OCP, obsessive–compulsive phenomena; SSRI, selective serotonin reuptake inhibitor.

Table 5.13 Assessing cranial nerve abnormalities

	Name	Testing	Importance
I	Olfactory	Omit: can be asked about	May be impaired in Alzheimer's disease or frontal lobe lesions
II	Optic	Ask about acuity Test fields by confrontation, both eyes at the same time: 'Which finger is wiggling?' Assess pupillary reaction to light and examine disks for swelling or atrophy	Important to detect a field defect as this may aid localization (see above) Hemianopia implies a contralateral hemisphere lesion If visual inattention present (simultaneous finger wiggling) check parietal lobe function
III, IV, VI	Oculomotor, trochlear, abducens	Ask patient to follow your finger slowly, left to right, up and down; look to either side on command Ask about diplopia	Opthalmoplegias are part of Wernicke's encephalopathy Palsies of nerve III (eye down and out) and nerve IV (eye cannot abduct) are seen after head injury Acute lesion of III suggests raised intracranial pressure
V	Trigeminal	Test sensation left and right on mandible, maxilla, and forehead Ask patient to clench his/her jaw	Trigeminal neuralgia can occur after herpes zoster infection; excruciating pain can lead to suicide Palliate with carbamazepine or antidepressants

Table 5.13 Continued.

	Name	Testing	Importance
VII	Facial	Observe facial symmetry	Beware paucity of facial expression in depression and Parkinsonism
VIII	Auditory	No need to test formally	Congenital rubella may result in deafness (plus cataract and low IQ)
IX, X	Glossopharyngeal, vagus	Listen to the voice and inspect the palate as patient says 'Ah'	Lesion here (lower motor neuron) results in a bulbar palsy which may be due to tumour, MND, myasthenia gravis, etc. Pseudobulbar palsy (bilateral upper motor neuron lesion deafferenting the bulbar nuclei) leads to dysarthria, a slow tongue, and a brisk jaw jerk; often accompanied by emotional lability and a gait apraxia (*marche á petit pas*)
XI	Spinal accessory nerve	Ask patient to shrug his/her shoulders	
XII	Hypoglossal	Inspect tongue at rest; ask patient to stick out tongue	

Neurological screening examination of children aged over 5 years

Children with known physical conditions or a history suggestive of a physical condition (e.g. epilepsy) should have a full neurological examination rather than the short screen described here.

1 Inspect ordinary gait.
2 Ask child to mimic:
  (a) heel–toe walking
  (b) tiptoe walking (possible above 3 years, usually no associated movements above 8 years)
  (c) hopping on each leg (hopping begins at 3–4 years)
  (d) kicking a ball of paper.
3 Inspection, particularly of hands and face, for dysmorphic features.
4 Touch fingers in turn with thumb; test finger–thumb coordination bilaterally (most 6-year-olds and some 5-year-olds can do this; mirror movements are usually absent after 10 years)
5 Check for dysdiadochokinesis on rapidly alternating hand movements (pronation–supination, 15 seconds each side).
6 Touch my finger: repeat three times for each hand (possible above 3 years, with eyes shut above 7 years); note tremor, consistent deviation.
7 Stand up, arms out, fingers spread for 20 seconds. Age 4 upwards: look for chorreiform (small, jerky, irregular) movements of fingers. Over age 6: eyes closed, mouth open, tongue out; look for asymmetry and drift.
8 Close inspection of eyes including ocular movements. Visual fields to confrontation.
9 Check face and jaw movements and power: whistle, smile, blow out your cheeks. Note tongue movements, wiggle tongue, lick upper lip.
10 Child removes shoes and socks (check shoes for uneven wear):
  (a) check muscle power and tone in arms and legs
  (b) check tendon and plantar reflexes
  (c) check feet for dysmorphic features
  (d) measure head circumference and plot on percentile chart
  (e) measure height and weight, and plot on percentile chart
  (f) estimate pubertal status (Tanner stages described on reverse of percentile charts)
  (g) observe how child puts socks and shoes back on.
11 Test hearing: ask child (in a quiet voice) to name a large toy at a distance of 1 metre
12 Check visual acuity (well-lit Snellen charts)

If abnormalities are detected the child should have a complete medical history and a full neurological examination.

The mute or inaccessible patient

Definitions

Mutism is the inability or unwillingness to speak, resulting in the absence or marked paucity of verbal output. It may be isolated but often occurs clustered with other disturbances of behaviour, level of consciousness, affect, motor disturbance, or thought processes, and may be due to organic or non-organic disorder. **Stupor** is a term used by neurologists as a stage on the continuum with comatose, implying reduced consciousness, but in common psychiatric terminology it constitutes preserved awareness with severe psychomotor inhibition. Mutism is invariably present in stupor. In general, these terms should not be used in isolation, but should be combined with a detailed description of the clinical features.

History

The history will need to be obtained from informants: relatives, keyworkers, neighbours, etc. In particular, the following should be established. How long has the patient been mute? Was the development sudden or gradual? Was there a stressful precipitant, or did the patient seem overly sad or happy in the prodrome? Is the mutism partial or complete? Is it specific to one situation (e.g. school)? Does any of the patient's behaviour seem odd or bizarre? How does the patient function in everyday life: eating, drinking, sleeping, continence, social activities, etc.? Is there a past history of psychiatric disorder, conversion disorder, or neurological or medical illness? What drugs have been prescribed/taken?

Examination

A general examination of physical state—temperature, pulse, blood pressure, and state of hydration (look at the tongue)—should be undertaken. The presence of mutism also demands a full neurological examination, beginning with an assessment of the level of consciousness. An impaired level of consciousness or the presence of focal neurological signs should lead to prompt referral to a physician or neurologist.

In particular, investigate whether the patient can articulate (by making lip movements or whispering) or phonate (by humming or coughing). Take note of the eye movements. Is the patient watchful, making purposive movements implying awareness of surroundings? (Beware 'roving eyes' in the unconscious patient, but if the patient is lying down and the examiner moves the patient's head, the stuporous patient will fixate on a particular point.) Are the eyes deviated to one side or another? (Eyes deviate away from a focal lesion, but towards an epileptiform focus during a seizure.) Does the patient with closed eyes resist opening? Is reclosure of the eyes slow and uniform, as occurs in the unconscious patients (this cannot be simulated) or is there resistance?

Is communication possible by other means (e.g. writing/signing)? Are there any attempts to speak? To what extent is comprehension affected? (Pure motor (Broca's) dysphasia is normally accompanied by frustrated attempts at communication and comprehension is relatively intact.)

Speech delay is evident in a substantial minority of children with elective mutism.

Mental state

Note the state of mental arousal and motor activity. Is there associated motor retardation? What is indicated by facial expression? does s/he appear elated, anxious, frightened, sad, or angry? Describe any grimaces, gestures, or mannerisms. Is there any evidence of attempts at communication, or does the patient seem unconcerned by his/her state (e.g. is there 'belle indifference')? Does s/he appear to be preoccupied, perhaps by hallucinations, ruminations, or paranoia?

Differential diagnosis of mutism

Psychiatric disorders

- **Psychotic disorder**: mutism may occur as a response to a delusional system in schizophrenia or as part of the negative symptoms in association with reduced drive.
- **Affective disorder**: mutism in depression may result in psychomotor retardation or nihilism, whereas in mania it may occur as part of a manic stupor.
- **Elective mutism**: this is most often seen in children, where there is emotionally determined selectivity in speaking; it is associated with social anxiety, withdrawal, or sensitivity.
- **Pervasive developmental disorders**: the use of language is delayed and often idiosyncratic, although mutism is rare. It is accompanied by impairments in social interaction and a restricted range of interests.
- **Obsessional slowness**: this may be accompanied by severely restricted speech output.
- **Somatoform/dissociative disorder**: in psychogenic dysphonia, the ability to phonate may help in differentiating it from an organic condition. Post-traumatic stress disorder may also be accompanied by mutism.
- **Factitious disorder**: this is rare, but may occur in situations where divulgence of information may be detrimental (e.g. with a pending court case).

Neurological disorders

- **Lesions** of cortex (e.g. frontal, speech areas), brainstem (e.g. akinetic mutism: coma vigil, 'locked in syndrome'), basal ganglia (e.g. Parkinson's disease, Wilson's disease).
- **Infective**: herpes encephalitis, HIV-related disease.
- **Drugs**: neuroleptics (may cause dystonic reactions involving tongue and jaw muscles, as well as torticollis, laryngeal spasm, and occulogyric crises), lithium, sedatives, antiepileptics.
- **Seizure-related**: during or after complex partial seizures, absence attacks, partial status.
- **Deafness**: may give rise to speech delay in children and impaired production of speech.

Investigations

Investigations should include haematology, biochemistry including blood sugar, toxin/drug screen, syphilis serology, endocrine screen, chest radiography, EEG (which may indicate localized epileptiform activity, although its absence does not necessarily exclude seizures), and brain imaging with CT or MRI.

Initial treatment

Once serious neurological disorder has been excluded, a period of observation is often valuable, although the presence of severe psychomotor retardation in depressive disorder or manic stupor may require urgent treatment and electroconvulsive therapy (ECT) should be considered. Treatment of dystonic reactions should be initiated rapidly, as they are frightening and painful for patients. Intravenous or intramuscular procyclidine is spectacularly effective.

The catatonic patient

Definition

Catatonia is a term which was originally associated with a variety of psychiatric illnesses, and later specifically with schizophrenia. It is currently recognized as a non-specific syndrome which occurs in a variety of organic states as well as in psychotic, affective, and somatoform psychiatric disorders. Catatonia is characterized by abnormal motor behaviour, with periods of hyper- and hypoactivity. Mutism and stupor are common, and it is often associated with features such as posturing, waxy flexibility, negativism, impulsiveness, stereotypies, mannerisms, command automatisms, echopraxia, or echolalia.

History

The ability of the catatonic patient to give a history may be preserved, and history-taking should then proceed along normal lines. More commonly, however, communication is impaired, and assessment must be undertaken as for the mute patient, questioning relevant informants. If communication is possible, the patient should be asked about any meaning attached to the postures adopted, which may lead to the uncovering of a delusional system, the degree to which the patient is distressed by the motor symptoms (it is important to distinguish from the mental and physical agitation of neuroleptic-induced akathisia), and whether passive movement is painful (which is often the case in waxy flexibility). Also ask about previous episodes of catatonia, as well as past psychiatric history.

Examination

As with mutism, the presence of catatonia demands full physical examination. Patients may shift rapidly into a period of catatonic overactivity which could render people close by in physical danger; therefore vigilance should be retained during examination. The catatonic patient is at risk of dehydration, rhabdomyolysis, sepsis, venous thrombosis, and

pressure sores, and examination should pay particular attention to these factors as well as excluding the organic causes of catatonia. The following phenomena should be elicited where possible:

- automatic obedience: a robot-like response to any instruction, however silly
- negativism: a similarly stereotyped response, but the opposite of what was requested
- waxy flexibility: the patient's limbs can be moved slowly into a new posture passively, but return gradually to the previously sustained posture
- 'psychological pillow': on lying down the patient's head remains held a few inches above the bed
- ambitendence: the patient begins to make a movement, but before completing it begins to make the opposite movement
- echolalia: the patient repeats the examiner's words or phrases
- echopraxia: the patient repeats any movements made by the examiner
- mannerisms: repetitive goal-directed behaviour
- stereotypies: repetitive non-goal-directed behaviours.

Differential diagnosis

Psychiatric disorders

- **Affective disorder**: depression is probably the most common psychiatric cause of catatonia and is considerably more common than mania. It often develops slowly; therefore the history may be particularly informative.
- **Schizophrenic disorder**: 'catatonic schizophrenia' is relatively rare now in Western practice, although catatonic motor disorders (i.e. a part of the catatonic syndrome) are commonly seen in all subgroups of schizophrenia. Catatonia is a relatively common presentation of puerperal psychosis.
- **Obsessional slowness**: catatonic features may be due to severe obsessive–compulsive disorder. Access to the typical mental state (with ruminations and obsessions) may be available with observation or from the informant's history.
- **Somatoform/dissociative**: this is rare and requires both the absence of physical or functional psychiatric aetiology, as well as positive evidence of psychogenic causation.

Neurological disorders

- **Lesions** of cortex (frontal and temporal lobes), brainstem, basal ganglia, limbic system, or diencephalon (e.g. tumour, cerebral thrombosis or haemorrhage, head injury, infection including encephalitis lethargica and syphilis).
- **Drugs**: neuroleptics (neuroleptic malignant syndrome—catatonia with rigidity and temperature/autonomic instability), lithium, morphine derivatives.
- **Toxins**: carbon monoxide poisoning, alcohol damage, ecstasy, alcohol.
- **Seizure-related**: simple partial or complex partial seizures.
- **Systemic**: renal or hepatic failure, endocrine disorders, connective tissue disorders (particularly cerebral systemic lupus erythomatosus).
- **Other**: acute intermittent or coproporphyria, vitamin deficiency.

In addition, there are a proportion of patients who present with recurrent catatonia in whom no psychiatric or neurological disorder can be found. This subgroup seems to be familial, and spontaneous recovery is the general rule.

Investigations

Investigations should include haematology, biochemistry including blood sugar, toxin/drug screen, syphilis serology, endocrine screen, chest radiography, EEG (which may indicate localized epileptiform activity, although its absence does not necessarily exclude seizures) and brain imaging with CT or MRI. In the case of diagnostic difficulty, abreaction may reverse the catatonia of the functional psychoses for a short time, allowing the emergence of 'hidden' psychopathology. The response to a single session of ECT may also be useful diagnostically.

Initial treatment

Supportive treatment, including fluid and electrolyte replacement, antibiotics, and anticoagulation should be initiated where indicated. Once treatable neurological causes have been excluded, consideration should be given to the early or even emergency use of ECT, as patients are at risk of a number of physical complications. Benzodiazepines, intravenously and then orally, have been shown to be of value acutely whilst neuroleptics begin to take effect. Neuroleptic malignant syndrome should be considered a medical emergency, and advice should be sought urgently. Initial treatment is discontinuation of the neuroleptic, supportive treatment of autonomic and temperature regulation failure, and treatment with dantrolene, benzodiazepines, and dopamine agonists.

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Chapter 6

The formulation, the summary, and progress notes

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A **summary** is a descriptive account of collected data; it is objective and impartial. In contrast, a **formulation** is a clinical opinion, weighing up the pros and cons of conflicting evidence, which leads to a diagnostic choice. An opinion inevitably implies a subjective viewpoint by virtue of assigning relative importance to each piece of evidence; in doing so, both theoretical bias and past personal experiences invariably come into play. No matter how accurate the final verdict, an analysis is inextricably bounded up with subjective judgments and decisions. When assessing the same patient, two experts may produce two similar summaries, but two different formulations with divergent conclusions. This is the fundamental difference: a summary is descriptive, whereas a formulation is analytical. Therefore a summary calls for the qualities of thoroughness, restraint, and objectivity, while a formulation demands the composite skill of methodical thinking, incisive analysis, and intelligent presentation.

Formulating a case with clarity and precision is probably the most testing yet most challenging and crucial part of a psychiatric assessment. The skill of writing a good formulation depends upon the ability to differentiate the merely incidental and circumstantial biographical details from the salient and discriminatory features forming the cornerstone of a clinical diagnosis. Certain features are discriminatory because they support one diagnosis as the more likely candidate and discount another diagnosis as less likely.

The formulation

A diagnosis involves a **nomothetic** (literally 'law-giving') process. This means that all cases included within the identified category have one or more properties in common. In contrast the formulation is an **idiographic** process (literally 'picture of the individual'). This means that it includes the unique characteristics of each patient's case which are needed for the process of management. Therefore, while nomothetic processes are the only way we can advance knowledge about diseases, we use idiographic methods to understand and study the individual.

The format of the formulation

The formulation follows a logical sequence.

Demographic data

Begin with the patient's name, age, occupation, and marital status.

Descriptive formulation

Describe the nature of onset (e.g. acute or insidious), the total duration of the present illness, and the course (e.g. cyclic or deteriorating). Then list the main phenomena (i.e. symptoms and signs) characterizing the disorder. As you become more experienced, you should try to be selective by featuring the phenomena that are most important because of either their greater diagnostic specificity or their predominance in severity or duration. Avoid long lists of minor or transient symptoms and negative findings, but include those that help to exclude other possible diagnoses. These basic data are chiefly derived from the history of the present

illness, the mental state, and physical examinations, and are used to determine the syndrome diagnosis in the next section. Note that this is not usually the place to bring in other aspects of the history; that comes later. If we know the diagnosis of a previous episode of mental illness, this should also be taken into account, but remember that the present disorder may not be connected and the diagnosis may be different.

Differential diagnosis

List in order of probability all diagnoses that should be considered and include any disorders that you will wish to investigate. These will usually be syndrome diagnoses based on the descriptive formulation above. Give the evidence for and against each diagnosis that you consider. Include any current physical illness which may account for some or all of the phenomena. A common error is to include, for example, thyroid function studies in the investigations without including thyroid disease in the differential diagnosis. If you think that a condition is worth investigating, then you are obviously including it in your differential diagnosis; if it is not worth mentioning, then do not bother to investigate it.

Remember that you will frequently need to consider supplementary diagnoses in addition to the primary diagnosis; for example, alcohol dependence in a patient presenting with delirium, or a personality disorder in a patient with an anxiety state.

Aetiology

The various factors that have contributed should be evident mainly from the family and personal histories, the history of previous illness, and the premorbid personality. It may be helpful to order aetiological factors by making reference to the biopsychosocial model of illness. This suggests that you organize the aetiological factors relevant to an individual presentation according to biological, psychological, and social factors, subdividing each domain into predisposing, precipitating, and perpetuating factors Try to answer two questions: Why has this patient developed this particular disorder? Why has the disorder developed at this particular time?

Investigations

List all investigations that are required to support your preferred diagnosis and to rule out the alternatives, and also any that you think are required to improve your understanding of the aetiology. Give reasons for investigations if they are not self-evident. Remember that the thorough investigation of an illness requires effective enquiry into all the relevant domains of the bio-psychosocial model; hence include psychological investigations as well as relevant social enquiry.

Treatment

Outline the treatment plan that you wish to follow. This should stem logically from your discussion of the aetiology as well as from the diagnosis.

Prognosis

Describe the expected outcome of management of this illness episode, with regard to both the symptoms and subsequent function (e.g. self-care and return to the community). Consider the risk of subsequent relapse.

The summary

This is an important document which should be drawn up with care. Its purpose is to provide a concise description of all the important aspects of the case to enable others who are unfamiliar with the patient to grasp the essential features of the problem without needing to search elsewhere for further information.

The first part should be completed within a week of admission and be arranged for typing under the following headings.

- Reason for referral, and referrer
- Present illness
- Family history
- Personal history
- Childhood
- Occupations
- Marriage and children
- Premorbid personality
- Physical illness
- Previous mental illness
- Medication and treatment history
- Physical examination
- Mental state

The summary of the psychiatric examination should cover all important aspects of the mental state, and be drawn up under whichever of the subheadings in the main schema are necessary to achieve this. The six subheadings of personal history listed above should always be included, and others from the main schema introduced as appropriate.

The second part should be completed within a week of discharge and be laid out under the following headings.

- Investigations
- Treatment and progress
  - Include details of medication prescribed and response; also note any significant side effects or reasons for changing medication. Document any other therapeutic strategies introduced. It is also helpful to document any significant episodes during the admission.
- Final diagnosis (or diagnoses) together with the ICD-10 diagnostic code number
- Prognosis
  - Make a predictive statement related to symptoms and social adaptation, rather than terms like guarded, good, or poor
- Condition on discharge,

Include keyworker, discharge medication, and follow-up arrangements; care plan.

The completed summary should be short enough to occupy about two sides of A4 paper when typed. A summary is necessarily a compromise between the need to document all the significant aspects of an admission and economy. The summary of a readmission should include the full range of categories listed here, unless the last admission was very recent and it has been established that no significant change has occurred in the family history and personal history in the interim.

References to highly confidential matters (criminal acts, sexual revelations, etc.) should be included only if their omission would produce serious distortion of the overall picture. Often it will be preferable to include only a veiled reference followed by 'see notes' in parentheses. The summary should identify which professional workers are to be responsible for different aspects of the patient's care in the future.

Progress notes

Regular progress notes, *signed and dated*, are a vital part of every case record. They should describe the treatment that the patient is receiving (with dates of starting and finishing, and dosages of all drugs), significant changes in mental state, and any important events involving the patient. They should also record the opinions expressed by consultants at ward rounds and case conferences. In particular, you should record the reasons supporting significant changes in management. Although these notes must be detailed enough to convey an accurate picture of the patient's treatment and his/her response to it, they should not normally contain lengthy verbatim accounts of conversations between patient and doctor. Notes which are excessively long are never read.

Handover notes

A handover note should be written whenever the patient is transferred from the care of one junior doctor to another, summarizing the salient features and outlining future plans. This is particularly important in the case of outpatients for whom there is no formal summary or formulation.

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Special interview situations

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The patient who demands proof that you care

Some very lonely people rely on their doctors and other professional attendants for social contact. Many of these accept the limitations and boundaries of the professional relationship and 'play the game' by generating the kinds of problems they know you deal with: side effects of medication, new somatic complaints, etc. A small number make escalating demands based on the assertion that you do not really care—it is only a professional relationship to you. In order to demonstrate that you do care, you may find yourself putting them at the end of an outpatient clinic so that you can spend longer with them than with other patients. Then you may find that everyone else has gone home by the time you finish the consultation. As you recognize the person's really desperate state you may encourage him/her to telephone you between appointments. Then, as it is clear that once-weekly visits to the clinic are insufficient, you find yourself offering extra appointments outside working hours. By this time you have a Very Special Patient, although often none of your tokens of care are having the desired effect. Far from the patient becoming happier and more able to face independent life, you are now apparently indispensable to this special patient's very survival. Indeed, suicide threats and gestures may be used to ensure that you remain centrally involved in the care. Frightened childlike behaviour may elicit an impulse to comfort the patient—holding hands, an arm round the shoulder. Resist the temptation: you are in danger.

It is not that such people are not desperate and lonely and have not suffered terrible deprivation and cruelty in childhood. It is only that you will never be able to prove that you care enough, not even if you were to adopt them into your own family. (Incredibly, such things do happen.) The danger for you is that a central motivation in becoming a doctor—the relief of suffering and the wish to heal damaged minds and bodies—is being distorted and your professional identity is under threat. Sexual contact between doctor and patient is far from uncommon, and may happen as the result of a series of short steps, starting as outlined above. The contact can be heterosexual or homosexual, and it is an unequivocal breach of professional ethics.

The cardinal rule in caring for patients who demand proof that you care is not to become isolated with them. The first step is to seek supervision from senior colleagues, and the second is to arrive at a care plan involving the multidisciplinary team. Ongoing psychodynamic supervision of such cases is essential to optimize care and to protect the carers.

The patient who solicits erotic involvement

From time to time a patient may develop an erotic attachment to the doctor and declare undying passion. Sometimes this can be managed by

simply explaining that it is impossible for you to continue as the doctor if you are treated as a potential lover. Indeed, this may be the unconscious motivation of the patient's attraction, so that one could pose the question: 'What is it about my being your doctor that you wish to avoid?' Assessment of the underlying disturbance is essential, as such declarations may (among others) be the expression of extreme loneliness, the manifestation of a personality disorder, or the presentation of a potentially dangerous delusional disorder. Whereas you might try to work through the disturbance with the patient in the first two cases, this is not an option in the last.

Whatever the disturbance, if the patient persists importunately there is no alternative but to transfer care to a colleague, explaining that further contact between you and the patient will henceforth cease. Further harassment and stalking are matters for the forensic psychiatrist and possibly the police.

When such cases arise it is important to examine one's own dress and behaviour to ensure that one is not unconsciously signalling availability or even behaving seductively towards the patient. A good rule of thumb is to seek supervision of such cases from a senior colleague and possibly a psychotherapist. Supervision is also valuable as you tread the delicate balance between not giving the patient any encouragement and not inflicting unnecessary humiliation.

The patient who brings gifts

In psychiatry one might expect expressions of gratitude less often than in other specialties. Nevertheless, patients do bring gifts from time to time. There may be no problem with a parting gift at the end of a course of treatment, when it is often appropriate to accept it graciously unless it is cash. Gifts presented during the course of treatment are more likely to be complicated and to contain a hidden message. Find a way of addressing this without being churlish. For example, work the patient has done (pottery in occupational therapy, a poem, or a painting) may be important signs of competence and recovery; they may also be a concrete token of the patient's wish to remain in your mind and be part of your non-professional life. This is better put into words than left unspoken, and acceptance of the gift may be appropriate when the air has been cleared.

Ever more extravagant and inappropriate gifts might suggest that the patient has privately elevated you to a demigod, to be placated and propitiated, and perhaps expects untold benefits in return one day. This is a more direct attack on the professional relationship and needs to be addressed: 'I really cannot accept such an expensive gift; I wonder if you fear I will not take you seriously if you come empty-handed', or some variation on this.

The patient who is disinhibited

At its most harmless, disinhibition might take the form of personal remarks, tactless jokes, or asking personal questions. Do not rise to personal remarks or laugh at tactless jokes, and firmly fend off intrusive

personal questions. In general, respond in a muted and subdued way rather than returning an inappropriate affective tone.

More difficult to deal with is the patient who enters your personal space to touch, stroke, or hit you. Depending on the patient's mental state, and with the milder forms of intrusion, you might try distraction; for example, 'You were telling me about the voices that you hear'. More overt intrusion is less easily dealt with, and you may have to withdraw and try again later, or return accompanied by a nurse. It is especially important to do this if the doctor is examining a sexually disinhibited patient of the other gender. Physical aggression calls for back-up, and you should always have access to an emergency button when seeing a potentially violent patient.

The patient who refuses to leave

Stand at the end of the consultation to signal firmly that it is over. Say, 'I am afraid I am going to have to ask you to leave'. Appeal to the person's better nature: 'If you don't go now I will be keeping others waiting' (this of course may be the reason that the patient will not leave). Finally, say 'I am going to call for someone to escort you out of my room' and telephone for help. This is preferable to any attempt to coax or manhandle the patient on your own.

The patient out of hours

Be prepared: expect the unexpected. Many awkward situations arise because the doctor has been only half awake to the fact that psychiatric patients, at least from time to time, do not behave reasonably.

If you are called out of hours to see a patient whom you do not know on a ward or in Accident and Emergency (A&E), as far as possible inform yourself about him/her before the interview. Read the medical and nursing notes, especially the admission summary, formulations, care plans and reports of management and ward-round decisions. Ask to be briefed by the senior nurse on duty or by the accompanying friend or relative of the patient in A&E. Where possible, ask the nurse to be present while you interview the patient and never conduct a physical examination alone. If for any reason you decide to interview the patient on your own, first of all be clear how to call for help.

Position yourself within reach of the telephone and know the number to call for help. Be sure that there is somebody within earshot who knows to respond quickly to raised voices or to sounds of furniture being violently relocated. If there is a 'panic button', stay within reach of it. It is generally safer to position the patient nearer the door, leaving the path to the door uncluttered, as a paranoid or fearful patient is more likely to leave than attack if that possibility is open. If the patient produces a weapon, terminate the interview as quickly as possible by explaining to the patient that it is impossible for you to help someone who is armed, but that the consultation can be resumed once the weapon has been

handed over for safe-keeping. Leave as soon as you have said this, if the patient will allow you to do so; offer to fetch a cup of tea or coffee to allow the opportunity to think about what you have said. If the patient will not allow you to leave, stay calm and chat to him/her about neutral matters; if you can press the panic button without risk to yourself, do so.

The patient who demands drugs

Often the story given is one of a lost prescription or of sudden motivation to stop illicit drug use. There are no rules about how to deal with this situation but the following points may help.

- Take a good history of exactly which drugs and how much the patient is consuming.
- If s/he claims to have lost a prescription, who was it prescribed by? Can you check with them? Where is it being dispensed? Pharmacists keep good records and will often be open late.
- Do not prescribe unless you feel confident that you are doing so safely.
- Never start a prescription that cannot be continued safely (e.g. by a local addiction service).
- Remember that opiate withdrawal is not physically dangerous but benzodiazepine withdrawal and alcohol withdrawal can be.
- The patient has probably been using illicit drugs for a long time. S/he can continue for another day or two until an appropriate referral is made.
- Try to consult a specialist.

The patient who threatens violence

Even the most skilful clinician will occasionally be faced with a patient whose behaviour escalates such that physical assault seems imminent, or who even offers violence (but see Chapter 1, p.10). Usually, this arises when some real or perceived threat to his/her physical or psychological integrity has made the patient either very frightened or very angry—essentially, s/he feels that things are getting out of his/her control. Particularly high-risk situations include interviewing patients whose delusional beliefs are that harm is imminent, or telling a patient of a clinical decision to detain or treat him/her against his/her will. Patients who are disinhibited by drugs or alcohol are especially prone to sudden aggression.

Much can be done to defuse a crisis before violence erupts, and not just for your own benefit. Other staff will avoid the risks of coming to your aid, and the patient will escape adverse labelling and possibly even a criminal conviction. Anticipate your interview with an unknown, possibly disturbed, patient by doing the following.

- Read the records for information about the patient's likely mental state and any previous history of violence and substance misuse.
- Ask the nursing staff about his/her current behaviour and concerns, and whether they think s/he has been drinking. Junior nursing staff will often defer to you on the question as to whether the patient is safe to interview alone (even if you know far less about him/her than they do) unless you make it clear that you value their views.

- Arrange to use an interview room that can be easily observed by staff who know where you are, or who are prepared to wait outside if necessary. Ideally, the room should have an alarm button that is close to hand, and the door should be easily opened from the inside.
- On the other hand, the room should also allow for a degree of privacy and quiet.

The interview itself should be conducted in a polite and, if anything, slightly formal manner; not only will this promote a psychological distance between you and the patient which discourages violence, but by treating him/her as someone important, you will increase his/her self-esteem. Ideally, the room should be arranged so that each of you has an unobstructed route to the exit. Do not invade his/her personal space, touch him/her, tower over him/her, or sit behind a large desk; rather, make an effort to build rapport. Tell the patient who you are and that you want to do your best to help him/her. Take time to listen to his/her concerns, and if they are delusional, acknowledge his/her fear, distress, or anger rather than arguing about their veracity.

It often helps to tell the patient that s/he is frightening everyone, as s/he may genuinely be unaware of this. Similarly, asking a female relative or member of staff to sit in with you may help to modify his/her behaviour.

These techniques will fail with some patients, especially if they have been drinking, have very fixed beliefs, or are very aroused. If your intuition tells you that all is not well, listen to it. If you are clearly getting nowhere, do not increase the patient's frustration by prolonging the interview unnecessarily. Typically, the matter can only be resolved by telling the patient that you want him/her to do something, such as stay in hospital, take medication, or go into the seclusion room. By now, you will know that this is going to be provocative, and if you are alone with him/her it will usually be best to leave the room and fetch help; if necessary, tell the patient that you are going to consult a senior colleague. Confronting such a patient with medication should only be done with a control and restraint team in the room with you, and with the medication prepared and ready to be administered.

The assessment of dangerousness

Recently, the general approach to the problem of 'dangerousness' has altered. The central focus has shifted from the question of whether a particular patient is or is not 'dangerous' to an assessment of the risk s/he poses in a particular situation under specific circumstances. This paradigm shift has facilitated clearer thinking about patients' potential dangerous behaviour in that it highlights the importance of psychiatric decision-taking, the information on which decisions are based, and their underlying logic.

Theoretical framework

Recognize that some level of risk is present

Just as the psychiatrist will automatically consider the likelihood of his/her patient committing suicide, so thinking about whether the patient may harm others must become routine. As with suicide, sometimes the risk of

violence is unmistakable. However, on other occasions it may be much less so. While apparently obvious, it needs to be stressed that recognition that the risk exists is the essential first step in the assessment of the likelihood of self-harm and violence to others.

In the case of suicide, actuarial data have helped to raise the question of risk in an individual by pointing to his/her membership of a vulnerable group. Similarly, the possibility of violent behaviour may be signalled by certain demographic and historical features of the patient's case, most importantly, a history of previous violence.

Define specific aspects of the risk(s)

Having become concerned that there is a risk, the psychiatrist should:

- define the risk and estimate the **seriousness** of the potential harm
- make an estimate of the **probability** that the risk will become reality
- estimate the **imminence** that the risk will become reality.

Formulate a plan of management to reduce risk(s)

Such a plan will utilize the detailed account of the risk behaviour in terms of the nature of the act, circumstances, the victim(s), precipitating factors, and substance misuse to inform risk-reducing interventions. Note the importance of an explicit timescale.

Practical risk assessment

Assessments will vary according to the case and circumstances. Those undertaken to decide on transfer from a maximum security to a medium security hospital will differ from that carried out in the emergency clinic on an unknown man who has been behaving oddly in public. It is not only a question of the differing resources and information available. The purposes of the assessments, the relative urgency of the decisions to be taken, and the period for which such decisions will hold sway are completely distinct.

The practical process of risk assessment can be thought of as three stages: gathering and reviewing all **documentation** from all possible sources, **examining the patient** and **interviewing informants**, and **asking yourself questions** concerning the patient, the circumstances, and the potential victims. From the documentation and interviews the psychiatrist aims to gain as complete a picture as possible of the index behaviour and its immediate antecedents; the patient's recent and longer-term history, the patient's social and physical environment (with recent changes), and the patient's mental state. Close attention should be paid to those areas where there are discrepancies between the patient's own account of his/her history and behaviour and those of other observers, particularly involved family and nursing staff.

The index behaviour

Frequently, risk assessment is required for patients who have already been violent or have threatened violence. In such cases it is of the utmost importance to record a detailed account of the index behaviour and its antecedents. The patient will provide a partial picture, which may significantly minimize the violence. Any objective description is of great value, particularly witness statements recorded by the police. In addition to enabling analysis of the violent behaviour, witness statements often

give a sharp and immediate sense of the emotional impact of the behaviour, an impact which is readily lost as the story is repeated through successive hospital admissions.

Such an account of the index behaviour may provide clues to the prevailing mental state which are otherwise unavailable. Psychosis may be suggested by disorganized behaviour, apparent response to hallucinations, or bizarre actions. The patient may appear angry, afraid, or lacking in emotional response. His/her actions may appear planned, impulsive, or a response to frustration or a shaming experience. S/he may have used a weapon defensively or with grossly excessive violence.

The immediate and medium-term antecedents

The immediate antecedents of the index violence may suggest precipitating factors. The patient may have suffered or be threatened by the loss of someone important. S/he may have experienced rejection or loss of face. His/her accommodation or financial security may be at risk. S/he may have refused medication or increased his/her misuse of drugs or alcohol. Evidence of relapse may be evident without obvious cause. A pattern of change may be evident in the patient's life, culminating in the index offence. S/he may have become increasingly socially isolated and withdrawn, or may have moved home ever more frequently, staying settled for increasingly short periods of time. Such 'social restlessness' has been seen as an ominous sign in the histories of particular psychotic perpetrators of irrational violence.

History from the patient

A comprehensive psychiatric history is an essential part of all risk assessments with additional attention to certain specific domains.

1. Each incident of **previous violent behaviour** should be described. All behaviour bringing the patient into contact with the police should be ascertained, with the outcome recorded in terms of charge, conviction, and sentence, including details of time spent in custody or on probation. Violent and criminal behaviour that did not come to police attention should also be recorded from as early as possible in the individual's life. So-called 'domestic' violence should not be neglected. Patterns (e.g. escalation in seriousness or decline in frequency) should be noted.

2. The patient's **exposure to violence**, both as victim and witness, should be documented from the earliest stage of his/her developmental history and should include experiences 'in care'. While the mechanism is ill understood, victims of abuse are at increased risk of becoming perpetrators in their turn as they utilize defence mechanisms such as identifying with the aggressor.

3. The patient's **psychiatric career** should be reconstructed with attention to such factors as mode of presentation, previous diagnostic formulations, whether admissions to hospital have been against the patient's will (under the Mental Health Act), the nature, efficacy, and time course of response to therapeutic intervention, and the various facets of insight including acceptance of medical explanations and advice, compliance with treatment, and spontaneously seeking psychiatric help. The success of outpatient management or the reasons for its failure are of particular importance. It may become clear that there is a constant

relationship between psychiatric illness and violence and aggression, or on the other hand that there is no relationship whatsoever.

4. The history of **alcohol and drug misuse** must be taken in detail, with particular attention to the relations between drug use and psychiatric illness and between drug use and violence and aggression. These may be multiple and complex; for example, violence when intoxicated may precede mental illness, drug use may exacerbate pre-existing psychotic symptoms associated with violence or precipitate relapse leading to violence, increased drug use may be an attempt by the patient to 'treat' his/her symptoms, or criminal activity to finance a drug habit may follow loss of employment as a result of psychiatric illness.

5. The **psychosexual and relationship history** should be explored in detail. Childhood experience of sexual abuse significantly increases the chances the adult will become a perpetrator. A pattern of short unsuccessful intimate relationships may indicate one of a range of disorders of personality. Some understanding of attitudes to the opposite sex and sexual fantasies should be sought. Sexual psychopathology, including dysfunction or abnormal sexual preference, should be noted, especially if the latter has been acted upon outside a consensual relationship. Sexual partners are relatively frequent victims of severe violence associated with mental disorder, particularly if pathological jealousy is involved, and a pattern may be discernible over a series of relationships.

Circumstances

Thought should be given to how the patient's situation contributed to the index behaviour. Who was s/he in contact with? Was the behaviour of friends or family a factor, for example by encouraging drug or alcohol use or by discouraging compliance with treatment? Did the pattern of the patient's daily activities make the index behaviour more likely? Was the patient's accommodation appropriate?

The question of why the patient's victim was originally involved must be addressed. Was the victim a stranger, an acquaintance, or a family member? Was the victim selected as an individual, a member of a category, or at random?

Mental state

Just as a potentially suicidal patient should be asked about self-harm, so a potentially violent patient should be questioned explicitly about his/her intentions. S/he should be asked about specific victims (especially if threats have been made), methods, and plans.

Particularly associated with violence in psychosis are delusions of being under threat, of being controlled, and of having one's will overridden by some outside force. Acting on delusions is more likely if the delusions are associated with fear, suspicion, anger, or perplexity. Threats made by the patient must be taken seriously, as should violent fantasies. This applies as much to patients manifesting profound depression who suggest that their families would be better off dead as to threats to kill uttered in anger.

The patient's insight should be examined in terms of his/her acceptance that s/he is ill, his/her agreement to take medication, and his/her understanding of the true nature of his/her psychotic experiences. Relative lack of conviction as to the truth of a delusion should not be

seen as reassuring, as acting on false beliefs may be more likely if they are shakily rather than firmly held.

An exploration of the patient's inner world is as important as the clarification of external circumstances. The meaning of precipitating factors and the resultant violence to the patient is as important as the actual event. This is similar to finding out whether someone taking an overdose of what might seem a trivial amount actually thought it was a lethal dose. Complete denial of the index violence or denial of personal responsibility for it is of ominous significance, as is lack of remorse. The patient's attitude to any treatment s/he has received should be noted.

Relevant features of the patient's personality should be assessed. Personality strengths such as the ability to make friends or cope stoically with adversity may reduce risk. Deviousness or deceptiveness increases uncertainty. The damage to the personality seen frequently in schizophrenia may in some cases reduce the risk of violence by diminishing spontaneous activity. On the other hand, the actions of such patients are more difficult to predict because of reduced access to their mental state.

Risk assessment: synthesis

Defining the seriousness of the potential harm, the probability that it will occur, and its imminence requires making sense of an often considerable amount of information. Patterns should be sought in the patient's development as a child, an adolescent, and an adult, which will contribute, to a complex picture of the patient, his/her circumstances, and his/her interaction with the potential victim. Prediction is facilitated by comparing and contrasting this picture with that of other patients with similar diagnoses, both known to the clinician personally and in the research literature.

Risk management

The purpose of risk assessment in psychiatry is the prevention of future harm by appropriate intervention. An effective strategy will change those aspects of the patient's situation and mental state which require changing and can be changed. It will also take account of important influences on behaviour, such as brain damage, which are not susceptible to intervention. Most importantly, the effects of each intervention should be monitored. Thus long-term risk management involves a continuous process of assessment of risk followed by intervention followed by reassessment of risk, which either confirms risk reduction or indicates that the intervention has been unsuccessful. In other words, patient management is continuously subject to **feedback monitoring**.

The multidisciplinary team should determine strategy and tactics for the management of patients who pose significant risk, especially for those individuals who will have specific roles in management. Success depends on the effective functioning of the team and on the **clear apportioning of responsibilities** within the team. Poor communication both within the team and between the team and other involved agencies has been held responsible for failures of management and the tragedies that have ensued.

Effective risk management involves breaking down a single large decision into a series of smaller steps. Thus, to decide that a given patient is unlikely to attack anyone before s/he is seen in the clinic in a fortnight is a realistic possibility, whereas accurately predicting whether or not s/he will be safe in the indeterminate future is much less so. His situation in the community in terms of friends and family as well as support services can only be reliably predicted in the short term.

Plans should be made to cover such eventualities as can be foreseen. These should be written down and known to the relevant members of the team. As stated above, all plans should include provision for effective monitoring so that both successful and failed interventions can be noted. Appropriate responses in the event of the failure should be clearly spelt out. It is obvious that risk management plans must take account of what is available locally, but it is equally obvious that plans may break down if a necessary minimum of community resources is not available.

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Special problems

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Childhood autism

Children and adults with autism or other autistic spectrum disorders demonstrate a combination of impairments in social relationships, communication, and the development of imaginative interests. The most distinctive aberrations are the difficulties that they show in reciprocal social interaction, understanding the mental states of other people, sharing their interests, and forming friendships and intimate relationships. Their language lacks the usual social quality and is preoccupied with idiosyncratic concerns. It may be lacking in quantity (e.g. used only to ask for needs to be met) or it may be plentiful but repetitive and more of a monologue than a conversation. Pronoun reversal (e.g. 'you' for 'me'), delayed echolalia, and stereotypical speech are common features when language is reasonably well developed. (Immediate echolalia is seen, but is also very common in simple language delays and children who are just learning to talk.) A restricted and repetitive range of interests and behaviours is very typical, and life may be dominated by incessant rituals, with distress and rage if trivial aspects of daily routine or environment are changed. Partial forms of the disorder exist; the full form is usually very persistent. Long-term advice and supervision are required, and families need support. Specialized educational resources can be recommended; behaviour therapy techniques can promote communicative development and reduce unacceptable and challenging behaviours.

Hyperkinetic disorder

This is a combination of impairments involving an excess of activity, especially in situations expecting calm, inattentive and disorganized activity in every situation; and an 'impulsive' unwillingness to wait for gratification, share with others, or take one's turn. A multimodal treatment approach is usually needed in the management of this disorder in order to promote academic and social learning, improve emotional adjustment and self-esteem, and relieve family distress. Behavioural approaches, with particular emphasis on speed of reinforcement, can be helpful both at home and in school. Drug treatment, especially with stimulants such as methylphenidate or dexamphetamine, is a powerful way of reducing hyperactive behaviour. Therefore stimulant medication is included in the treatment package of behavioural and educational support in the case of children with severe hyperkinetic disorder.

Specific developmental disorders

These occur when there is an impairment of one or more developmental functions that is markedly out of keeping with the general level of development. For some functions there are reliable and valid tests that have norms for different ages; for example, specific reading retardation occurs when performance on a standard reading test is worse than the fifth centile allowing for age and IQ, and it should be diagnosed by a psychologist's

quantitative assessment. For other mental abilities (e.g. calculating) norms are much less satisfactory. For others again, such as motor delays and impairments of memory and attention, the diagnosis still has to be made on the basis of the clinical assessment. Remedial education can be given for all these problems, once the problem is recognized. Counselling for the child and family may be needed to help in the prevention of secondary psychiatric dysfunction. (See section on assessment of development on pp.52–3, 56–7)

Suicide and deliberate self-harm

How common is suicide?

Suicidal behaviour is a major public health problem. According to a World Health Organization (WHO) parasuicide study conducted in 13 European countries, including the UK, the average annual rates of suicide attempts are 136 per 100 000 for males and 186 per 100 000 for females. The annual rate of completed suicide in the UK is less than 10 per 100 000, which accounts for 1 per cent of all deaths. Suicide is the ninth leading cause of death among the general population in developed countries, and among adolescents it takes the third place in the ranking of causes of death. Eight to ten people attempt suicide for every one who completes it; thus the lethality of self-harm behaviour is high. The adequate assessment, management, and ultimately prevention of suicide is probably the most essential skill for a psychiatrist.

Useful definitions

The concept 'suicidal behaviour' involves a continuum of behaviours ranging from suicidal thoughts to successful suicide. Full consensus on terminology has not yet been reached. The following definitions, based on ICD-10, will be used in this book.

- **Suicide:** a wilful self-inflicted life threatening act, which has resulted in death.
- **Parasuicide:** a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognized therapeutic dose. The term **suicide attempt** is often used in referring to cases of parasuicide involving intention to die.
- **Deliberate self-harm (DSH):** a deliberate non-fatal act committed in the knowledge that it was potentially harmful and, in the case of drug overdose, that the amount taken was excessive.

The essential distinction is between those who commit suicide (completed suicide) and those who survive after harming themselves (parasuicide and DSH). The challenge for the psychiatrist lies in that there is substantial overlap between the two.

Risk factors for suicide: features from the history that are associated with increased risk of suicide

The main risk factors are as follows.

- **Statement of intent:** about two-thirds of those who die by suicide have told someone about their intentions. It is a misconception that those who talk about suicide do not act upon it.
- **History of previous suicide behaviour**: in the WHO multicentre study on parasuicide over 40 per cent of the sample had a history of at least one previous suicide attempt. Nearly 20 per cent of all repeaters made their second suicide attempt within 12 months after the first.
- **Presence of psychiatric disorder**: over 90 per cent of victims of completed suicide were suffering from a psychiatric disorder at the time of committing suicide. The prevalence of psychiatric disorders among parasuicide cases is also very high. Those disorders with a higher risk of suicide are major depression, bipolar affective disorder, schizophrenia, and drug/alcohol dependence.

Further risk factors of suicide to remember and recognize are:

- painful physical illness
- bereavement
- impulsive personality traits
- social isolation
- male sex
- unemployment
- low social class
- older age (however, risk is increasing in young men)
- previous history of DSH
- certain professions (doctors, veterinary surgeons, farmers)
- certain ethnic groups (Indian females).

Features associated with higher suicide risk

- Recurrent or persisting suicidal ideation (always remember to ask)
- Hopelessness
- Depression
- Agitation
- Early schizophrenia with retained insight (young patients who are aware of the implications of their illness and see their future ambitions restricted)
- Presence of delusions of control, poverty, and guilt
- Being under the effects of alcohol or other substance (intoxication = decreased self-control = risk)
- Personality trait of impulsivity

The systematic assessment of suicide/self-harm risk

(Table 8.1)

The assessment is aimed at identifying subjects at risk, estimating the chances of suicidal ideas leading to acts, and estimating the chances of repetition of suicidal behaviours. Prevention is the goal.

1. The patient recovering from parasuicide/self-harm needs to be physically stable before you conduct a psychiatric assessment. Assessment of drowsy patients after an overdose is unreliable.
2. A first and crucial step is routinely making tactful but direct inquiries about the patient's intentions. Asking about suicide does not make it more likely to happen.
3. An essential part of the assessment is to determine the presence of any psychiatric disorder, i.e. to conduct a thorough mental state examination and obtain a psychiatric history.

Table 8.1 Features conveying higher risk of repetition and eventually suicide

Higher risk	Lower risk
Previous parasuicide/DSH	First attempt
Attempt planned	Impulsive attempt (non-planned)
Attempt performed in isolation	Attempt performed in front of others
Precautions taken to avoid rescue	Rescue intervention is likely or actively sought
Violent method (hanging, gun)	Non-violent method (overdose)
Patient expected fatal outcome	Patient was unsure of outcome[a]
Regrets having been rescued	Relieved at being rescued
'Suicide note' or will written	No 'suicide note' or will written

[a] What matters is the patient's subjective intentions/expectations, irrespective of real medical seriousness.

4. All the risk factors discussed above need to be explored. There are scales to help to do this systematically and a flexible use of these is recommended (see the SAD PERSONS Scale and the Risk-Rescue Rating Scale in Appendix 3).
5. Identify any precipitating factors. Ask about life events, conflicts in areas of relationships, employment, finances, law/police, housing, sexual adjustment, physical health (especially HIV), and bereavement. Precipitating factors need to be addressed/resolved if further risk is to be prevented or decreased.
6. Finally, it is also necessary to evaluate the degree of support available from the environment of the patient. Assess the social support available and previous coping strategies. Could the patient's family or GP help?
7. If in doubt, always consult a more experienced colleague.

When these key aspects are fully explored a management plan will be established. When psychiatrists' interventions successfully prevent suicides no proof of efficacy exists, and often there is no acknowledgement; however, a completed suicide can be seen as a failure. This is not only an irony of our profession but also an increasing source of legal action. Practical advice is to write detailed records of your assessment in the notes and to monitor risk over time by making successive 'update assessments' for those patients staying under your care. Systematic and careful assessments leading to sensible treatment plans and regular reviews of progress are the way forward. (See pp.159–60 and Appendix 3, p.125 for details on the management of suicide and self-harm.)

Alcohol and drinking problems

Although the drinking history is acknowledged to be an important part of the psychiatric examination, it is often overlooked or patchy. Clinicians may feel that they are inadequately trained and too busy, or may perceive individuals with alcohol problems as 'too difficult' and time-consuming. This view can be reinforced by the frequent attendance of severely alcohol-dependent individuals in crisis—intoxicated, aggressive, or suicidal. However, taking an alcohol history is not the mere assimilation of facts. It is an opportunity to form a therapeutic relationship with the patient, to diffuse a difficult situation, and may even be helpful in itself.

Rather than confronting the patient with questions on quantity consumed and frequency of consumption at the outset, and risking a defensive reply, it may be more helpful to open with a non-specific question such as what s/he perceives as the main problem.

The alcohol history in the context of the background history

Family history

Family attitudes to alcohol; whether alcohol was kept in the house; the drinking history of parents, significant others, and siblings; family history of alcohol and other psychiatric problems.

Personal history

Birth history and milestones; school attendance and performance; peer relationships; truancy; educational attainment.

Occupational history

What occupation—whether working with alcohol; occupational problems related to alcohol (dismissal, absenteeism, frequent job changes).

Sexual and marital history

Sexual problems; history of childhood sexual abuse (particularly important in women with alcohol problems); HIV risk behaviour; marital problems related to drinking; separation; divorce; problems with children.

Financial and housing history
Housing problems; rent arrears; eviction; problems with neighbours.

Forensic history
Convictions for drink-driving, being drunk and disorderly, and violent behaviour.

Past medical and psychiatric history
Particular attention should be paid to alcohol-related physical and psychological problems and accidents. Specific enquiry should be made about depressive illness, phobic anxiety, pathological jealousy, suicide attempts, and drug misuse.

Basic personality
Ask the patient to describe what s/he was like before s/he developed his/her drinking problem.

Drinking history

Evolution of drinking and current alcohol consumption
Age of:
- first drink
- regular weekend drinking
- regular evening drinking
- regular lunchtime drinking
- early morning drinking.

Ascertain consumption at each stage, noting the type of beverage and quantity consumed as well as frequency. Note whether s/he prefers to drink in a group, alone in a social setting, or alone at home. Note whether there is any binge drinking and detail any periods of abstinence. Obtain alcohol consumption (units) for the past 24 hours, 6 months, and 12 months (1 unit = 8–10 g of alcohol which is equivalent to one glass of wine, half a pint of ordinary strength beer, or one measure of spirits).

Evolution of alcohol dependence
Note the age of onset of withdrawal symptoms and other features of the alcohol dependence syndrome (ICD-10):
- compulsion to drink
- difficulties in controlling alcohol consumption
- tolerance
- progressive neglect of alternative pleasures or interests
- persisting with drinking despite clear evidence of overtly harmful consequences.

Alcohol-related problems

Outline physical, neuropsychiatric, and social problems.

Physical problems
Gastritis, hepatitis, cirrhosis, pancreatitis, peptic ulcer, oesophageal varices, oesophageal carcinoma, seizures, cognitive impairment, peripheral neuropathy, cerebellar degeneration, anaemia, cardiomyopathy, myopathy, head injury, etc.

Neuropsychiatric problems
Memory blackouts, pathological intoxication, delirium tremens, depression, phobic anxiety, suicide attempts, pathological jealousy, personality change, sexual dysfunction, auditory hallucinations during withdrawal, alcoholic hallucinosis, eating disorders.

Social problems
Marital/occupational and financial problems; forensic history.

A typical recent heavy drinking day

Most patients can identify a typical recent heavy drinking day. Some cannot, and this may imply more variability in their drinking, possibly with a tendency to weekend binge drinking. Ask the patient to take you through the day from the moment of wakening. A description of the timing and consumption of the first drink, and the patient's attitude towards it, can be extremely helpful in determining the degree of dependence. Thus a man waking at 4.00 a.m., tremulous and drenched in sweat, who reaches out for the can of strong beer by the bed is at a different stage of dependence from the man who takes his first drink at lunch time. Likewise, the professional woman who drinks covertly from a bottle of vodka in a workplace lavatory at 9.00 a.m. is at a different stage from the woman who starts to drink at 5.00 p.m.

Other drug use

See next section.

Treatment history

GP; community alcohol team (statutory or voluntary); outpatient or inpatient treatment in general or psychiatric hospitals; residential rehabilitation; self-help group (Alcoholics Anonymous).

Drug dependence

When the answers to your screening questions, or other information (such as a routine urine drug screen), suggest that the patient has been using drugs, you will need to take a more detailed drug history. Below is a list of elements you will need to elicit, followed by a suggested schema and some suggested questions.

Important elements of the history

- Which drug(s) is the patient using?
- What is the frequency of use?
- What is the pattern of a typical drug-using day or week?
- What is the route of use (e.g. oral, smoked, snorted, injected)?
- What effect is the patient seeking when using the drug?
- Is there evidence of the physical or psychological features of dependence on the drug(s)?
- What risky behaviours does the patient engage in (e.g. injecting, sharing needles, unsafe sex, 'sex for drugs')?
- How long is the history of drug use and how has it evolved?

- What complications of drug use has the patient experienced (physical, psychological, family, occupational and legal problems)?
- What is the patient's past experience of treatment for a drug problem? Have there been any periods of abstinence, and if so, what has helped the patient to achieve this? What triggers have brought on relapses?

In addition, when you are taking a social history from the patient, assess the extent to which the patient's main social contacts are other drug users or whether there are friends, family, or others who do not use drugs and who could provide support.

Suggested schema for drug history

Current drug use

Which drugs does the patient currently use? Ask the patient to describe his/her drug use the previous day, and to take you through a typical drug-using day (which drug? how often? which route?). Ask also about the circumstances of the drug use; for example, some people will only use drugs in certain social circumstances such as ecstasy use at a dance party, while others may have a regular pattern of use which has developed to prevent the experience of withdrawal symptoms. Ask about a typical week if drugs are not used every day. Does the patient experience any withdrawal symptoms (ask the patient to describe them) or craving if the drug is not used? Ask about other symptoms of the dependence syndrome, such as increased tolerance to the drug and the priority of drug-seeking over other duties and pleasures. Is the patient currently engaging in any risky behaviour such as dangerous injecting (into groin or neck, or infected injection sites), sharing needles, or unsafe sex? How is s/he financing the drug use?

History of drug use

In addition to current drug use, ask the patient if s/he has used other drugs in the past. If the patient has used more than one drug, it is usually easier to take a chronological history of each drug in turn rather than to try to assess all of them at one.

Ask about the age at first use of the drug, and then when the patient began to use the drug regularly. Ask about maximum frequency and amount used, and about any periods of abstinence. When (if ever) did the patient first experience withdrawal symptoms of the drug? (Ask the patient to describe them.) If not currently injecting, has the patient ever injected, and ever shared needles? Has the patient engaged in other risky behaviour (as above) in the past? What influences have helped the patient to achieve abstinence and then later to relapse?

Complications of drug use

Physical complications

Include complications of the drug itself and complications of the route of use. Ask specifically about hepatitis and HIV (e.g. 'Have you ever worried that you might have caught hepatitis? or HIV? Have you had any tests?'). Also ask about other complications of injecting such as abscesses, deep vein thromboses, and septicaemia. Has the patient ever overdosed accidentally?

Psychological complications
Ask about the relationship of psychological symptoms to drug use. It may be difficult to tease out cause and effect, but some initial information will help in your assessment.

Family, occupational, and legal complications
Ask the patient about the effect of drug use upon these areas of his/her life.

Treatment history
Ask about previous experiences of seeking help for a drug problem. Has the patient had help from a general practitiioner, drug dependency unit, or non-NHS organization? What has it involved? For example, has the patient had prescriptions, or previous detoxification, or psychological treatment or self-help? What does the patient think was helpful in the past?

Current wishes and intentions
There are several possible goals in the treatment of drug misusers. Abstinence is one possible goal, but safer drug use may be a more realistic goal for some drug users (see section on harm reduction, Chapter 10, p.168). Ask the patient what s/he would like to do about the drug use.

Special points in the physical examination
In the physical examination, look for injection sites, including legs and groins. If the patient is injecting, ask him or her to show you the most recent injection sites. Look for abcesses or infected sinuses, and for evidence of deep vein thrombosis.

Checklist of information
By the end of the history, you should have enough information to know:
- whether the patient is a dependent drug user
- what risks s/he is taking in relation to drug use
- whether there are current problems related to drug use.

Sexual and relationship problems

Sexual dysfunctions and desire disorders

History
This is taken from both partners separately, at least in part, but much of it can be usefully obtained from a joint interview which also affords the possibility of direct observation of the couple. Features include the following.
- Nature and duration of the problem: is it a disorder of desire or of function?
- When was the last successful experience?
- Does the problem occur in all situations (e.g. with other partners or in self-stimulation) or is it confined to the present relationship?
- Does it occur at all attempts? If not, what proportion of the time?
- Factors that seem to make it better or worse.
- Reaction of patient and partner when the problem occurs.

- Any associated difficulty (e.g. anorgasmia in the woman accompanying premature ejaculation).
- Attempts to treat the problem so far (both in therapy and by couple's own initiative).

Associated factors: alcohol intake, smoking, spinal injuries, diabetes, hypertension, psychiatric illness and its medication, physical illness, surgical operations, stress, prior traumatic experiences (including sexual abuse or rape), recent life events, life-cycle stage, etc.

Quality of general relationship: communication, resentment, inhibitions, distance and closeness, invalidism, power, commitment. Any infidelities, satisfaction with sexual life, problems with fertility? Duration of present relationship, sexual preferences and practices, inhibitions? History from each partner, including sexual development, previous relationships and sexual experience, attitudes of family to sex, levels of knowledge, puberty, menarche, obstetric history, contraception, menopause, hormone replacement therapy, pelvic injuries or surgery, any sexual deviations, effects of ageing.

A full biographical and family history is often obtained via a self-report questionnaire before the couple are seen.

Masturbation (past and present): attitudes, guilt, fantasies, techniques, etc. Is orgasm achieved?

A **physical examination** is not always necessary. However, it is usually recommended in cases of erectile disorder and vaginismus. Physical examinations should be conducted by a specialist (e.g. a urologist or the patient's gynaecologist).

Diagnostic features

The problems presenting in the male are:

- erectile disorder (impotence)
- premature ejaculation
- delayed ejaculation
- loss of desire.

The problems presenting in the female are:

- vaginismus (painful spasmodic contraction of the muscles surrounding the vagina, usually impeding intercourse; it may be caused by fear or aversion to coitus but can also have organic aetiology)
- orgasmic dysfunction
- dyspareunia (pain during intercourse)
- loss of desire.

Problems deriving from the relationship include:

- incompatibility of sexual desire
- conflict over sexual preferences and practices.

Direct questions should be asked about the presence of morning or night erections (suggesting a psychogenic aetiology), alcohol intake, use of drugs, sources of stress, any psychiatric problems, diabetes, hypertension, spinal injuries, pelvic injuries or operations, genitourinary infections, etc.

There are no diagnostic tests which need to be done in cases of **ejaculatory or orgasmic dysfunctions**, but inquiry should be made about medication with SSRIs or other antidepressant drugs.

In **erectile dysfunction** there are some basic points which should be addressed. Enquiry should be made into the use of medication, including antidepressants, diuretics, gastric acid suppressants, and antihypertensives. Arterial blood pressure is a useful measure, as are reflexes in the lower limb and cremasteric reflexes, penile sensitivity, blood or urine sugar, and examination of the genitals. In erectile disorders the best source of information (if the test is available) is the intracavernosal injection of papaverine or prostaglandin; if an erection can be produced by this means vascular causes are excluded, but the differentiation between psychogenic and neurogenic causation is left open. This has to be determined on clinical grounds, but it is often necessary to assume a multifactorial causation. Further tests, including arteriograms and cavernosograms, should be reserved for those cases in which surgery is being contemplated.

In problems of sexual desire in men there is some benefit to be obtained from the measurement of hormone levels.

In cases of **vaginismus** a digital examination of the vagina is necessary to make the diagnosis, but in many centres this is done at a later visit than the first, when the patient is more comfortable with the setting.

Sexual deviations and gender dysphoria

History

Denial is a common phenomenon in those with sexual deviations. In order to obtain a truthful account it is useful to ask open questions and to approach the topic in a roundabout way, for example when interviewing a man with tendencies to abuse children.

- Details of the **deviant behaviour**: how often, where, when, with whom, whether caught and/or convicted, whether fantasies are associated, etc.
- What thoughts and feelings are experienced? What visual images or materials are used to achieve arousal? Does the person have a normal sexual outlet as well as the deviant one? What are the masturbatory fantasies?
- How high is the sexual drive (may be judged by masturbatory frequency or desired frequency of ejaculation)?
- How dangerous is the activity? Is it against the law? Does it damage the patient or others? Is there any empathy with possible victims?
- Do family members or partner know about the activities? What is their attitude?
- Past criminal history (this problem or others).
- Is the patient motivated by the wish to change his/her behaviour or simply to avoid punishment?
- Is there an associated sexual dysfunction in more 'normal' sexual activities?

In cases of **gender dysphoria** has there been a wish to be a member of the opposite sex from childhood, or is it more recent in origin? Has it occurred in the course of a depressive or psychotic illness? Has the patient thought through all the implications of sex change for him/herself and for his/her family and friends?

Diagnostic features

Variations and deviations can be divided into those which are harmful to others and those which are either solitary or harmless. Deviant sexual behaviour is predominantly a male problem, but it should be remembered that, especially with child abuse, women can also be perpetrators.

Harmful deviations include sexual abuse of children, whether general (paedophilia) or confined to family members (incest), rape (heterosexual or homosexual), indecent assault, exhibitionism, voyeurism, obscene telephone calls, stalking, frotteurism (touching people sexually in crowds), stealing clothing (to use fetishistically), and the more dangerous forms of sadomasochism including sex murder.

Relatively harmless deviations are usually solitary, and include cross-dressing for the purpose of sexual arousal, autoerotic asphyxia, and various forms of fetishism including leather, rubber, shoes, underclothes, or different parts of the body such as feet. Other solitary deviations include cross-dressing for sexual arousal in the presence of the partner, the use of fetishistic objects with the partner, and some of the more benign forms of sadomasochism such as domination-submission, bondage and spanking.

Transsexualism is not usually defined as a deviation, but is included here because there seems no more suitable place to discuss it. There are generally no biological abnormalities in these patients.

Couple relationship therapy

History

This is not usually a major part of couple therapy, and in some centres it is elicited by prior completion of a questionnaire by each partner. What is required is a basic version of the general psychiatric history, including presenting problems, and (for both partners) family history, personal history, previous relationships, current relationship, children, personality, and a brief symptom checklist.

In more psychodynamic settings the history comes out gradually in the course of therapy. Some systemic therapists spend time with genograms or diagrammatic family trees in order to help in understanding family influences. In most clinics the therapist is as interested in the observed interaction of the couple in therapy as in the history as such.

In the couple interview, therapists will elicit details of the presenting problem, other strains in the relationship, the general satisfaction and commitment of both partners, the good aspects and troublesome aspects of the relationship, the risk of divorce or separation, problems with children, housing and financial problems, sexual satisfaction, and what attracted them to each other.

Have there been major quarrels or violence? Infidelity? What are the resentments on both sides? Do they confide in each other? Who is more upset by the current problems?

Diagnostic features

These are more concerned with the couple relationship rather than the individual, and involve such factors as closeness–distance, dominance–submission, alliances and boundaries, repetitive sequences of interaction, role-taking by each partner, and relationships with other family members and outsiders.

Eating disorders

History

Many sufferers from eating disorders feel extremely ashamed about what they are doing and may find your questions very taxing and painful. Others are ambivalent about whether they want help; in some cases the denial is so extreme that they feel that there is little or nothing wrong with them and have merely come to the clinic because of the extreme concerns of their family or partner. Particularly in these latter cases, it is important to establish an individual relationship with the patient rather than to relate exclusively to the family.

These patients arouse strong feelings which range from anger and irritation through to the desire to rescue and protect. This is probably because their interpersonal schemas include a mixture of a drive to please others, a sense of inferiority, and a drive to be in control. One of the most important parts of the management is to understand this transference and countertransference.

Behavioural assessment

At the simplest behavioural level the clinician wants to know the following by the end of the assessment interview.

- Is severe undernutrition present or significant overweight?
- Is there constant dietary restriction and/or are there episodes of overeating?
- What weight control measures are used?

These behavioural criteria easy to define and elicit, but they are also of clinical utility as they guide management.

Undernutrition or overweight?

This is addressed by measuring weight and height, and is usually done at the end of the interview with the physical examination (see below). A detailed lifetime weight and diet history is helpful. The patient should be asked when she first noticed a problem with her weight or when she first began to focus on weight as a topic of personal importance. Both the **rate** of weight loss and the **absolute level** are markers of dangerousness. Marked fluctuations suggest that there is self-induced vomiting or abuse of laxatives and diuretics.

The patient should be asked what her heaviest ever weight was and when this occurred, and similarly about her lowest weight. The weight at which her periods began needs to be established, as does the weight at which her periods stopped (if relevant). This is important, as the weight at which a patient's normal biological functions recover will generally be slightly above the former and so can give an indication of how much weight needs to be gained.

It is also useful to obtain a family weight history. There may be a strong family history of obesity in bulimia nervosa, or of leanness or eating disorder in anorexia nervosa.

Constant dietary restriction and/or episodes of overeating?

It is often necessary to question directly about bulimic behaviour as it may not be spontaneously mentioned because of the shame attached. A suitable line of enquiry is 'Do you have episodes when your eating seems excessive or out of control?' You need to probe gently to elicit whether the amount eaten is excessive (objective binge, >1000 kcal) or not (subjective binge).

What weight control measures are used?

In addition to dietary restriction the methods commonly employed are self-induced vomiting, chewing and spitting, abuse of laxatives, diuretics, street drugs (e.g. amphetamines and ecstasy), caffeine, prescribed medication such as thyroxine, or health food preparations and excessive exercise.

Mental state assessment

Overvalued ideas about shape and weight, in which the assessment of self-worth is made exclusively in these terms, are considered primary features of bulimia nervosa. Not all patients with anorexia nervosa express such ideas.

Body image distortion (a statement that they are fat when they are underweight) is no longer regarded as a necessary criterion for anorexia nervosa. A less culturally bound description of this phenomenon is that the emaciated state is overvalued.

The patient should also be asked what weight she would ideally like to be. Often patients with anorexia nervosa will try to please the therapist by giving a higher weight than they are aiming for. It may be helpful to probe into this in some detail: 'If you got to seven stone would you be happy there?' If the patient says 'no', it can be helpful to press her as this may help her realize that she has a problem: 'So if you were seven stone you might want to weigh six and a half, but what then?'

Additional psychiatric disorders

Over 80 per cent of subjects with eating disorders have additional psychiatric morbidity during the course of their life. Depression and obsessional symptoms are common in anorexia nervosa. Depression and anxiety disorders are common in bulimia. Symptoms of post-traumatic stress disorder are common in mixed anorexia nervosa and bulimia nervosa. Personality disorders are present in a half of cases referred to specialist centres.

Diagnostic features to look out for are:

- body mass index (BMI) less than 17.5 kg/m^2
- use of weight control measures
- spot diagnosis—physical signs such as parotid or submandibular gland enlargement, eroded teeth, 'Russell's sign' callus on back of hand, cold blue hands, lanugo hair.

BMI can be calculated as follows:

$$BMI = \text{weight (kg)}/[\text{height (m)}]^2.$$

Factors for converting from imperial to metric measures and vice versa are given in Table 8.2.

Physical assessment

Nutrition

Many patients find it very difficult to allow themselves to be weighed. It is important not to be drawn into a battle over this, and the higher in weight the patient is the more lenient you can afford to be. The ICD-10 definition of anorexia nervosa requires that the BMI is less that 17.5 kg/m^2 (this approximates well to the DSM-IV definition of 15 per cent below average weight).

Table 8.2 Conversion of imperial and metric measures for weight and height

	Imperial to metric	Metric to imperial
Weight	1 stone = 6.35 kg	1 kg = 0.16 stone
	1 lb = 0.45 kg	1 kg = 2.2 lb
Height	1 ft = 30.5 cm	1 m = 3.3 ft
	1 in = 2.54 cm	1 cm = 0.39 in

1 stone = 14 lb; 1 ft = 12 in; 1 m = 100 cm.

Cardiovascular system

The hands, feet, and nose are pinched, blue, and cold. In severe cases chilblains and, particularly in children, gangrene of the toes can occur. The heart rate is slow (<60 beats/min) and blood pressure is low (90/60 mmHg). A marked fall in blood pressure on standing (postural drop) is evidence of dehydration.

Skin and hair

The skin is dry and downy, and lanugo hair may be present on the cheeks, the nape of the neck, and the forearms and legs. The head hair may become thinned and dry so that it breaks off and sticks out. There may be a scar over the knuckles (Russell's sign) if the hand is used to induce vomiting. A petechial rash due to thrombocytopenia can occur with severe starvation.

Gastrointestinal system

Vomiting can lead to many physical consequences. The teeth may appear small and smooth, with the upper front teeth worn into an arch shape; alternatively the teeth may be deceptively even as if they have been crowned. The side of the mouth may be cracked. The face may appear rounded because of swelling of the salivary glands.

Skeletomuscular system

In severe cases a proximal myopathy develops. If this is present the patient may find it difficult to lift her arms to brush her hair. She may not be able to get up without help or without leverage from her arms if you ask her to crouch. Tetany can develop because of the metabolic alkalosis (common in vomiting).

Somatization

Somatization is the expression of emotional distress in physical terms, with medical help-seeking. At interview, most of these patients will fulfil diagnostic criteria for a psychological disorder (usually depression and/or anxiety), but will often deny that they have an emotional problem. This is a very common presentation of psychological disorder and is neither abnormal nor unusual.

It is essential that such patients are physically examined and receive any appropriate investigations. When results are fed back to the patient, it is essential that the doctor acknowledges that the physical symptoms are real and does not suggest either directly or by implication that the patient is 'nervous' or is exaggerating the symptoms. Instead, s/he is reminded of the other psychological symptoms that are present, and the presenting symptoms are 'reframed'. The way is then clear to explain the mechanisms by which emotional distress can cause physical symptoms.

Somatization disorder refers to the most severe cases, and is a diagnostic category to describe patients who report large numbers of somatic symptoms, have illness histories stretching back to adolescence, and are very frequent users of medical services. The disorder is uncommon, but is very demanding in terms of cost and time.

Taking a history from a patient with severe somatization can be difficult if one is a psychiatrist. The intention is to obtain the usual information on the mental state, but without challenging the patient or becoming too 'psychological'. Thus do not ask 'Are you depressed?', but 'Has all this got you down?'. Do not ask 'Do you feel like killing yourself?', but 'Have all your problems ever got too much for you?', and so on. Do not ask 'Do you get panic attacks?', but instead probe about whether or not certain situations, such as supermarkets or the tube, make the patient worse. The patient who tells you that s/he is made worse by neon lights, or whose 'brain gets overloaded by lots of conversations going on at once', may be experiencing phobic-related symptoms. Stress is a term that is often acceptable to patients when more direct psychological approaches fail.

One of the most important questions is 'What do you think is wrong with you?' The patient's illness model may explain much of his/her behaviour, as well as pointing to possible treatment avenues. Someone who is worried that when s/he has back pain his/her 'disk will slip again' and s/he will end up in a wheelchair will naturally restrict his/her activities. Many have similar 'catastrophic' cognitions': 'If I push myself I may never walk again, or I'll have a relapse'. Always ask 'What might happen if you continued [when you get the pain/feel exhausted/feel dizzy]?' and 'What is the worst thing that might happen to you?'

History

The medical and family history of patients with chronic somatization can be revealing. A history of previous unexplained symptoms is common: tonsillitis persisting after the removal of tonsils, 'grumbling appendix', prolonged recovery from normal infections, repeated gynaecological procedures, and so on. Illness may also run in the family; looking after parents with long-term illnesses (either physical or psychological) is

common. Previous episodes of ill-defined illnesses, such as candida or unusual allergies, are suggestive.

Always take a history of previous contacts with the medical profession. It is not advisable to criticize medical colleagues, but allow the patient to ventilate his/her distress at what may have been very unsatisfactory previous encounters.

Course

Subacute somatization is very common and the physical symptoms are likely to remit eventually. However, if the patient receives an endless series of negative physical investigations, it is only a matter of time before s/he develops a chronic form of somatization disorder. Patients attending specialist clinics with labels such as myalgic encephalomyelitis (ME) or chronic fatigue syndrome also have a gloomy outlook, associated with the strength of their physical illness convictions and the degree of avoidance behaviour.

Investigations

In general most patients with somatization disorder will already have had more than enough investigations. Once basic sensible investigations have been performed, further investigations will reinforce the sense that something organic is wrong. Investigations do not reassure such patients, and induce anxiety rather than relieving it. A better use of your time is to obtain as many medical records as you can.

Mother and baby problems

Pregnancy

At some time or another most general psychiatrists will look after female patients who are pregnant, and a detailed assessment of the mother's mental health and adjustment may be necessary for a variety of purposes or the reasons that are listed below. Maternal psychopathology in pregnancy is the same as psychopathology in other settings, and thus the principles of detailed history-taking and systematic mental state evaluation are the same irrespective of childbearing status. However, the interviewer should be sensitive to the fact that, in general, only a fortunate few expectant mothers conform to the stereotype of the pregnant woman who 'blooms ' with good health, and for many mothers early pregnancy is a time of tiredness, appetite changes, nausea, loss of libido, etc. There may be anxieties and concerns about the future, doubts about readiness for parenthood, and uncertainties about the stability of key relationships (e.g. with the partner). Fears, ruminations, and fantasies about the fetus may have a bearing on the mother's mental state, but may not be mentioned unless asked about and then only if the mother has confidence in the interviewer.

What is the personal and social context of the pregnancy? Is it a first baby? Have there been previous miscarriages and terminations? If it is a second or subsequent pregnancy, how old are the other children, are they in good health, and is the mother anticipating problems with the arrival of the new child? How much help and support does she have from family and friends, and how supportive is the expectant father financially,

practically, and emotionally? What is his mental health like? Thus the context of pregnancy imparts a particular focus to the psychiatric examination, and in terms of the mother's history it becomes especially important to know what her own experience of being parented was like and what experience she has had of looking after babies and little children.

Clinically significant depression and anxiety is not uncommon in early pregnancy and may be missed unless specifically asked about. Clinical judgement is needed to distinguish between psychosomatic concomitants of depression and changes which occur in pregnancy. For example, can a woman who wakes up at night to micturate go back to sleep easily? Does she wake feeling refreshed? Is there a diurnal variation to her tiredness and is her loss of appetite specific to certain kinds of foods? How does *she* construe her physical symptoms, i.e. does she ascribe them to her pregnant condition?

Some important reasons for psychiatric examination in pregnancy

Termination of pregnancy

Abortion legislation varies greatly across nations and it is not possible to generalize about psychiatric indications. Suicidal risk and the possibility of severe postpartum destabilization of mental health are among the most prominent psychiatric considerations in countries with relatively restrictive abortion laws. There are no *absolute* psychiatric indications or contraindications to abortion; that is, apart from religious, moral, and legal considerations, there are no psychiatric illnesses or indeed associated disorders (e.g. severe mental impairment) in which a woman's right to choose may be overruled on medical/psychiatric grounds.

Management of severe mental illness during pregnancy

Questions often arise about the teratogenic effects of prescribed and non-prescribed drugs. What balance is there between the putative benefits of discontinuing medication and a flare-up of maternal illness. Clearly, such questions can only be addressed in the light of a detailed knowledge of the mother's history and current state.

Welfare of the fetus; future safety of parenting of the newborn

Risks to the fetus may arise through infection, nutritional deficit, drug exposure, deliberate self-harm, and lack of compliance with antenatal care programmes. Thus the assessment of the mother's condition (e.g. chronic schizophrenia, eating disorder, drug dependence, personality disorder, depression, mental impairment, etc.) takes on an added urgency because of the risk to the unborn child, and this risk may enter the equation when assessing the need for compulsory treatment under the provisions of the Mental Health Act. Longer-term concerns about motivation and safety of parenting of the newborn should begin to be addressed during pregnancy in conjunction with social services. The psychiatrist may be asked to carry out an evaluation of the mother's mental illness, its history and prognosis, and her ability to manage her life in her personal and social context. There may be an inherent conflict between the mother's rights

and wishes to be the primary carer of her baby and the paramount need to ensure the child's welfare and safety.

Prevention and management of postpartum recurrence

The likelihood of recurrence of severe mental illness (manic depressive and schizoaffective disorder, and possibly also paranoid psychosis) is high. Relapse rates of up to 50 per cent are described, and therefore it is negligent not to plan ahead by liaising with obstetric and primary health care services and planning possible admission. Recurrence rates of non-psychotic depressive disorders are about 20 per cent. Accurate and expert antenatal assessment by a psychiatrist is essential for planned management at a time when the mother is in repeated contact with clinical (obstetric and primary health care) services. Motivation to change may be a major factor in helping some expectant mothers to alter patterns of behaviour (e.g. drug use and abuse).

After childbirth

The same general principles that applied to psychiatric examination in pregnancy also apply after the birth of the child. Thus some kinds of pre-existing mental illness have high rates of recurrence, but in addition childbirth itself is a major factor in provoking first onsets of both psychotic and non-psychotic affective disorder. There are three conditions, the names of which suggest a specific association with childbirth: maternity blues, postnatal depression, and postpartum or puerperal psychosis.

Maternity blues

These are near universal short-lived episodes of emotional lability, typically occurring around the fourth and fifth days postpartum. The most common picture is of dysphoria, but this may in some instances be mingled with or dominated by elation, prolixity, and overactivity. The blues themselves do not constitute an illness or syndrome, and the two main points of clinical interest are the identification of the characteristics of those women who go on to develop postnatal depression, and the distinction between the 'benign' self-limiting mood changes of the blues from the sinister prodromal symptoms of impending affective psychosis.

Postnatal depression

The symptoms of postnatal depression are the same as those of depression in other settings, but in addition the women frequently report ruminations of inadequacy and guilt about their ability to be good or competent mothers. Sometimes they describe feelings of aggression and impulses to harm the infant, which are very rarely acted upon but which induce further self-blame. Thus the assessment of depression after childbirth should always incorporate sensitive questions about the mother's feelings concerning her baby and should extend to include obsessional ruminations and rituals as well as psychological and behavioural manifestations of anxiety (e.g. irrational fears, social and agoraphobic behaviours).

Postpartum or puerperal psychosis

These are affective (manic, mixed, or psychotic depressive) disorders, sometimes with paranoid hallucinatory symptoms as well, which have an acute onset, usually at the end of the first or during the second week

after delivery. They are commonly described as coming on after a 'lucid' period of a few days, and the affective illness is often very fluctuating and rapidly changing in its presentation with swings of mood and sometimes coexisting manic and depressive symptoms. In addition, it is suggested that the presence of 'non-organic' confusion, i.e. perplexity and patchy disorientation, may be pathognomonic. However, it is entirely possible that any subject who is in the early stages of acute psychotic breakdown may present in a similar way.

At the moment there are no treatments that are rationally based on aetiological hypotheses, and thus the choice of drugs is based on a judgement of the predominant clinical picture. Repeated assessments may be necessary, and too frequent changes of medication leading to polypharmacy should be avoided. Such assessments should also take into account possible risks to the infant if mother and baby are admitted together. Risks may arise through impulse in response to hallucinations or delusions, for example that the baby is evil and possessed, or is highly critical of the new mother, or is immortal, or is an angel. Another major source of risk is through disorganization and neglect because the mother's interactions are too disturbed, for example because she is manic or agitated. Her interactions may be diminished because she is retarded, or they may be inappropriate because she is chronically and severely impaired and lacking insight as part of a schizophrenic illness. In such circumstances the psychiatric examination must synthesize the doctor's own evaluation of the mother's mental state and behaviour, both alone and in the presence of the baby, with the observations of nurses and other members of the clinical team. Decisions about whether temporarily to nurse mother and baby separately may have to be backed by compulsion under the provisions of the Mental Health Act. Similarly, decisions about when it is safe to reunite them must depend upon the psychiatrist's assessment of the mother's mental state, her insight, and her compliance with necessary restrictions.

Epilepsy and other neuropsychiatric syndromes

Epileptic seizures

Epileptic seizures are classified by onset into generalized or partial (clinical and EEG information facilitates this distinction).

Generalized epilepsy

- Absence ('petit mal') seizures, primary generalized ('tonic–clonic') seizures, and other seizures (myoclonic,tonic, clonic, atonic and atypical).

Partial (focal) epilepsy with or without secondary generalization

- **Simple partial seizures** ('auras'): sensory, motor, or autonomic. Consciousness is retained. Auras vary in their complexity from discrete sensory experiences to complex ideation and emotion. Their pattern tends to be constant and has localizing value. They are abrupt in onset,

intrusive and experienced passively, and represent the portion of the seizure for which memory is retained
- **Complex partial seizures** ('psychomotor seizures'): fugues, automatisms, and twilight state. Consciousness is disturbed at onset.

Epilepsy in childhood

History

Begin by asking for details of the **first attack** experienced by the child: age, circumstances, description, duration, how it was dealt with. Then obtain similar details about subsequent attacks.

Be careful to distinguish and obtain separate descriptions of all different kinds of attack. For each type of attack probe regarding the following points.

Pre-ictal

Precipitating events

Are they due to physical causes (illness, fever, etc.) or psychological causes (any stress or disturbance)?

Timing

Do they occur at any particular time of day or night? How long after last meal, etc.?

Altered behaviour or mental state before fit

Is s/he irritable, restless, confused, apathetic, etc. minutes or hours before the attack?

Patient's activity at onset

Do they occur while asleep, on wakening, or in full consciousness? Are they precipitated by overbreathing, watching television, walking out into bright sun, or any other change?

Ictal

Aura

What are the patient's subjective warning experiences? Ask the child whether s/he knows that the seizure is coming and what s/he notices first (giddiness, noises, lights, smell, funny taste, inability to speak, feels frightened, etc). If the child cannot describe this experience, s/he may be able to draw it.

Course

What is the first event noticed (noises, strange behaviour, cry, fall to ground, motionless stare, etc.)?

Posture during attack

Does the child fall, go limp, remain standing, slump back in chair, etc.?

Movements

Which parts move? One side or both? Synchronous or not (e.g. turning of head or eyes, tonic stiffening movements, clonic jerking movements, restless or semipurposive behaviour, automatic or repetitive acts, fumbling, mouth movements)?

Spread (march) of movements
Where does the fit start? Does it spread anywhere?

Consciousness
Is the child totally unresponsive? Aware, but unable to talk? Fully conscious and talking?

Colour changes
Does the child become pale, flushed, or blue?

Autonomic effects
Does the child become hot and sweaty, cold and sweaty, salivating, etc.?

Incontinence
Is there any incontinence of urine or faeces?

Injury
Is the tongue bitten or any other injury sustained?

Post-ictal

After-effects
Do they return to normal immediately or go to sleep or become sleepy? Are they confused? Is there any weakness or paralysis of arms or legs? Clumsiness? Difficulty with speech? Change of behaviour or emotional state? Other symptoms (e.g. headache)? Vomiting?

Duration and frequency of this type of fit
If not mentioned by parent ask specifically regarding the following.

1. **Generalized convulsive seizures** Are there ever attacks in which the child passes out completely? Are there movements of the arms or legs in any of these attacks (tonic–clonic or clonic–tonic–clonic)?
2. **Generalized absence seizures** Is there ever a momentary blank spell in which the child seems to be out of touch for a moment but does not fall down, and for which there is no memory subsequently? Are there any movements at all whilst this is happening?
3. **Other generalized attacks** Does the child ever make odd jerky movements (myoclonus)? Does s/he ever fall down suddenly without jerking or going stiff (drop attacks)?
4. **Simple partial seizures** Are there any attacks in which there are movements of the arms or legs, but the child does not pass out or lose touch?
5. **Complex partial seizures** Does the child ever have episodes in which s/he does not seem to be him/herself or does peculiar things?
6. **Reflex attacks** Does the child know how to stop an attack coming on? Ask him/her privately if s/he knows how to make an attack start.

Treatment
Is this by family doctor or paediatrician? Which drugs are used in what doses? (Calculate dose/kg/day: does it fall within the recommended range?) What side effects are there? Have blood levels been measured recently? What do the parents do during the attack?

Attitudes

Obtain parental attitude to the attacks. What did they think was happening during the first attack? What do they put them down to? What does the child put them down to?

Does the child have epilepsy?

- **Differential diagnosis** includes syncope, breath-holding attacks, sleep disorder, benign paroxysmal vertigo.
- **Pseudo-seizures** are more common in children who also have genuine seizures.
- Remember that **fictitious epilepsy** is not uncommon. Obtain the name of someone other than the parent who has witnessed an attack and who can be contacted (e.g. a schoolteacher).

Notes

1. Children who are suspected or known to have seizures need a complete physical examination.
2. If the child is asked to count to 100, hesitations may reveal brief absence seizures.
3. Starting anticonvulsants is a serious decision. If there is still doubt whether the child has seizures after a detailed history, consider asking the child to hyperventilate for 3 minutes. In susceptible children, this procedure will induce generalized absence seizures in most, and complex partial seizures in a proportion. If a good history of generalized convulsive seizures has been obtained there is no point in doing this test. In view of the potential danger, this procedure should be carried out only under careful supervision, including the availability of drugs and equipment for the management of status epilepticus.

Epilepsy in adults

History

Ask the patient if s/he has had a blackout recently and when exactly? Obtain a description of the attack. This should include a description by the patient complemented by a description from an informant who has witnessed an attack. The patient may have had more than one form of attack. Ask him/her to describe a typical attack from the beginning.

Pre-ictal

Can the patient (or close observer) predict when an attack will happen minutes/hours before it does. How? Change in mood (irritability, dysphoria)? Change in cognition (inattentiveness, confused behaviour)? Build-up of minor seizures (absences, myoclonic jerks). Do these features resolve once the attack has occurred?

The epileptic attack

The presence of aura indicates focal cortical onset and strongly suggests underlying brain damage or disease. Is there any immediate warning of the attack or does the patient lose consciousness abruptly? If there is a warning, how long does it last? Does it last long enough to take avoiding action? Auras rarely exceed 1 minute in duration. Enquire about the aura content. Alimentary (epigastric sensations) and psychic (déja vu,

hallucinatory) auras suggest a temporal lobe focus. A sensorimotor 'march' suggests a primary sensorimotor cortical focus.
- Is consciousness lost suddenly or gradually?
- Is the patient completely unconscious or does s/he retain some awareness of what is going on around him/her? If so, what?

What was the patient told of how s/he was while unconscious? Does s/he fall or slump to the ground or is s/he able to maintain his/her posture? Is s/he perfectly still or does s/he make movements? If the latter, are the movements rhythmic or irregular? Which parts of the body are involved? Are they more marked on one side of the body than the other? Is there any spread or are they generalized from the beginning? Is there any initial rotation of the head/eyes to one side?
- How long does this phase last?
- If the patient retains posture:
  - do they carry out any automatism (coordinated movement: fumbling, searching, etc.)?
  - is there any tongue/lip/cheek biting or urinary incontinence?
- After the patient appears to regain consciousness, how are they:
  - confused, sleepy, delayed speech recovery, quick recovery?
- Are any other epileptic episodes described:
  - absences, myoclonic jerks?

Course
- When was the first seizure?
- When was the patient first investigated? What was the patient/family told. When was s/he first started on anticonvulsants? Past seizure frequency? Present seizure frequency?
- Seizure pattern: Diurnal? Nocturnal (how is this recognized)? Both?
- Precipitating factors: Stress? Menses? Photic stimulation (self-induced flicker effect, television, nightclub stroboscope)? Lack of sleep? Non-compliance with medication?
- Predisposing factors: Family history of epilepsy? Difficult birth? Febrile fits during infancy? History of head injury, brain infection (meningitis, encephalitis)? Seizures following immunization?

Diagnostic features to look out for

Other diagnostic possibilities
- Pseudo-seizures: atypical features of the seizure (opisthotonos, pelvic thrusting, thrashing limbs, resists examination)
- Panic disorder: preceded by hyperventilation, chest discomfort, peripheral paraesthesiae, carpopedal spasm
- Alcohol-related: history of excessive alcohol consumption; seizures occur during drinking bouts or immediately after withdrawal
- Others: cardiac syncope, vasovagal episodes

Differential diagnosis of confused behaviours occurring in the context of epilepsy
- **Post-ictal psychosis:** follows exacerbation of seizure activity; post-ictal latent period of normality before psychotic symptoms begin; clinical picture dominated by confusion, hallucinations, and affective

disturbance (twilight state); history of previous episodes; usually lasts only a few days and is self-limiting
- **Post-ictal confusion:** history of recent seizure; patient confused and drowsy; usually resolves within about 2 hours
- **Alcohol intoxication:** evident signs of drunken behaviour; alcohol on breath; known history
- **Head injury:** careful neurological examination indicated if recent history of head injury or evidence of scalp/facial injuries
- **Anticonvulsant medication:** complaints of drowsiness, poor coordination; on examination nystagmus, dysarthria, and ataxia; there may be a history of recent change in drug dosage.

Immediate management

Related to epilepsy

1. If seizures are **well controlled**, find out from the patient who treated the epilepsy and where. Copy clinical correspondence with details of psychiatric diagnosis and treatment
2. If seizures are **poorly controlled**, obtain details of medication, check compliance, request plasma anticonvulsant levels, and, once available, correspond as above.
3. The patient is **confused and disoriented.** This will usually be due to post-ictal confusion, but see differential diagnosis of confused behaviours above. Post-ictal confusion will rarely exceed 6 hours. Observe until recovered; otherwise admit.
4. A **seizure** occurs. Most minor seizures are very brief and do not require any intervention. If a major tonic–clonic seizure occurs, ensure airway (turn patient on side and remove false teeth) and guard patient from hard-edged/cornered objects that could cause injury. Do not restrain or attempt to separate teeth. Give clonazepam 1–2 mg or Diazemuls 10 mg intravenously. If the seizure is prolonged (>5 minutes) or status (repeated seizures without intervening recovery of consciousness) develops, repeat injection and request immediate medical assistance. Prolonged seizure activity/status is a medical emergency which may lead to hypoxia, hypotension, and hyperthermia, and may result in permanent brain damage.

Related to psychiatric illness

In general immediate management is the same as it would be for the psychiatric condition if epilepsy were not present. However there are exceptions.
- An **acute psychotic illness** in a patient not known to be psychotic is usually post-ictal. Unless relatives are used to dealing with such episodes, it is best to admit.
- **Pseudoseizures:** the clinician may suspect, and even observe, a seizure that appears non-epileptic. It is better to pass these observations on to the GP/specialist who usually treats a patient's epilepsy rather than comment directly. If in doubt treat as for epilepsy.

Response to treatment

Commonly prescribed anticonvulsant drugs

- **Carbamazepine, phenytoin, phenobarbital**, and **primidone** are first-choice anticonvulsants against most seizure types with the exception of general absence seizures (petit mal). The last two drugs are rarely prescribed now because of their potential as drugs of abuse.
- **Lamotragine**, a more recent drug, is effective against a wide range of seizure types including generalized absence seizures.
- **Sodium valproate** is a first choice in primary generalized epilepsy, but less so in partial epilepsy.
- **Ethosuximide** is a first-choice drug against generalized absence seizures.
- **Clonazepam** is a first-choice drug against myoclonic and atypical generalized absence seizures.
- **Clobazam, gabapentin,** and **vigabatrin** are second-choice anticonvulsants against partial and secondary generalized seizures.

Careful monitoring of anticonvulsant blood levels is essential, especially at times of change in drug regime. Some patients with intractable epilepsy may be eligible for brain surgery.

Course

In most patients (approximately 80 per cent) seizures will be effectively controlled by the first anticonvulsant prescribed. In patients with additional neurological and neuropsychiatric disabilities, control may not be so readily achieved and polytherapy may be unavoidable. Partial seizures are more difficult to control than primary generalized seizures.

Generalized absence seizures usually resolve by the third decade. Seizures developing for the first time in middle or late life may be associated with progressive underlying pathology and should be investigated with particular care.

Investigations

The investigation of newly suspected epileptic seizures includes an EEG and, particularly in the case of partial seizures, a search for a primary cause. This includes brain imaging (CT, MRI) and routine haematological and biochemical tests. A waking scalp EEG will only show relevant abnormalities in about 50 per cent of cases; a sleep EEG is often more informative. In the case of epilepsy of late onset, periodic rescanning may be desirable.

When there is considerable doubt on clinical grounds about the epileptic nature of the seizures and the routine EEG remains negative, a prolonged EEG (telemetry)/video recording may capture a seizure and confirm or refute the diagnosis. In most centres this investigation is carried out over a 5-day period whilst the patient is in hospital. Seizures must occur with sufficient frequency for this to be an effective investigation.

Patients considered for surgery may undergo tests that assist in localization. These may include telemetry with special electrode placement (foramen ovale, subdural, intracerebral), specialized MRI procedures (volumetric hippocampal measurements, proton spectroscopy) detailed neuropsychological assessment, carotid amytal measurements to determined cerebral dominance and lateralization of memory function, and measures of cerebral blood flow (single-photon emission CT, positron-emission tomography) to identify any filling defect.

Head injury

Behavioural and psychosocial problems following head injury are numerous and influential. The Glasgow Coma Scale, duration of coma, and degree of post-traumatic amnesia (PTA) predict the severity of the head injury. A PTA of 24 hours is seen as a watershed: below this full recovery can be expected; above this some degree of cognitive impairment is expected. A closed head injury with a PTA of 4 weeks or more is likely to be followed by invalidism extending over the greater part of a year.

Distinguish between open and closed injuries; the former carry a higher risk of epilepsy. Contusions occur typically after closed head injury, where the acceleration/deceleration forces and shearing forces lead to damage from localized small-vessel bleeding or local destruction. Scattered intracerebral haemorrhages are also found at the interface between grey and white matter. Medial orbital frontal and temporal pole surfaces are key vulnerable areas. Diffuse axonal injury (also known as 'diffuse white matter damage') must be considered. This occurs in white matter tracts of the cerebral hemispheres, including the corpus callosum (leading to atrophy and diffuse ventricular enlargement), and the brainstem, particularly the cerebellar peduncles. Over the first 24–48 hours axons break up, forming 'retraction balls'. Clinical findings will depend on the severity and extent of brain damage, and include prolonged coma in the absence of a focal brain lesion, severe cognitive impairment and personality change, and neurological signs, particularly from involvement of long tracts in the brainstem and cerebellar peduncles.

A severe head injury leads to emotional and behavioural problems in about 70 per cent of cases, and these tend to manifest in the year after injury. Impaired self-control and impulsivity, as well as increased dependency and apathy, are evident. There is difficulty in learning from experience, even when new information is retained. Post-traumatic neurotic disorders, particularly anxiety and dysphoria, are seen. Psychosis can occur, with delusions of misidentification observed early in the course of recovery, often associated with more generalized disturbances of insight, judgement, and disorientation.

Early-onset dementias

Creutzfeldt–Jakob disease (CJD)

CJD is a rare progressive dementia transmitted by infection with a prion (slow virus particle). Spongiform encephalopathy develops, possibly after a prodrome of anxiety or depression. Intellectual decline is followed by spasticity, ataxia, and myoclonic jerks. The terminal stage is of muteness and rigidity, with death occurring within 2 years. The EEG may show a characteristic triphasic pattern. Treatment is palliative.

Pick's disease

Pick's disease is a rare, probably hereditary, dementia classically affecting the frontal lobes initially, but pathology also shows knife-blade atrophy in the temporal lobes. Women are affected more than men. Presentation is usually

between the ages of 50 and 60 years. Early symptoms are of personality change and selective speech disorder, and later other 'frontal' features as well as memory impairment. Neuroimaging (MRI) reveals frontal, and sometimes anterior temporal atrophy. Treatment includes genetic counselling.

Huntington's disease

Huntington's disease is an autosomal dominant disorder (triple repeat on short arm chromosome 4). Presentation is usually in the fourth decade of life. Men are affected more than women. There is an insidious onset of involuntary choreiform movements affecting the face, head, and arms. Initially these can be disguised by the patient. Depression or explosive outbursts may occur. Later, a progressive dementia and athetoid movements are evident. The disease duration is 12–16 years. Results of investigation include a 'flat' EEG and caudate atrophy on MRI. Early disease may be detected by looking for decreased metabolism in the caudate with functional neuroimaging. Treatment is with low-dose haloperidol or tetrabenazine.

Parkinson's disease

The mean age of onset in this familial disorder is 55 years. Cogwheel rigidity, festinant gait, and bradykinesia are well known, but psychiatric features such as depression are very common. Anti-parkinsonian drugs are linked to a variety of psychiatric side effects, especially psychotic and hallucinatory disorders. In the older patient, arteriosclerotic parkinsonism is frequent, and cognitive impairment here is recognized and associated with the concentration of Lewy bodies. Management should involve liaison with a neurologist.

Normal pressure (communicating) hydrocephalus

Onset is often in later life, but this dementia is potentially reversible. Gait ataxia, cognitive impairment, urinary incontinence, and nystagmus are the clinical features. Cerebrospinal fluid (CSF) pressure is normal most of the time, but imaging can reveal enlarged ventricles and cortical atrophy. Treatment is a ventriculo-peritoneal shunt.

Amnesic (Korsakoff's) syndrome

This is due to thiamine deficiency, CNS poisoning, or hippocampal damage. Retrograde amnesia (failure to recall events before onset of the disorder) and anterograde amnesia (poor memory for events after the onset of the disorder) are present. There is impaired ability to learn and disorientation for time, but immediate recall is often preserved. Confabulation occurs, perhaps as the patient realizes that there is a memory void, but is not diagnostic. There is not an overall global cognitive decline. Treatment is for the underlying cause, but total recovery is exceptional.

CNS infections

Human immunodeficiency virus (HIV)

HIV dementia is now thought to be the most common dementia in young people. Insidious onset with subtle impairment of memory and concentration are observed initially. Apathy and withdrawal, or social disinhibition, also occur. Poor balance, dysarthria, and tremor can be found, but severe global decline and profound psychomotor retardation rapidly develop. Death due to opportunistic infection, aspiration pneumonia, etc. is the outcome within 2 years for 90 per cent of cases. Space-occupying lesions such as lymphoma are well recognized in HIV disease, and require treatment at a specialist unit. Delirium and a paranoid psychosis as a result of HIV are also reported. These are treated in the usual way. Adjustment disorders, anxiety, compulsive rituals, and depression are all amongst the psychiatric sequelae of HIV diagnosis.

Neurosyphilis

Neurosyphilis, which is caused by *Treponema pallidum*, is now a rare form of organic psychosis and dementia. Frontal lobe involvement is common, leading to personality change, and there is a gradual deterioration in memory and intellect. Depression is often a presenting feature. Argyll–Robertson pupils (small, irregular, and unreactive) are seen in over 50 per cent of cases. Later there is a lower limb weakness, resulting in a spastic paralysis. Serum and CSF Venereal Diease Research Laboratory (VDRL) and *T.pallidum* haemagglutination antibody (TPHA) tests are positive. High-dose penicillin with steroid cover (to avoid the Herxheimer reaction) is the standard treatment.

Cerebrovascular disease

Cerebrovascular accident (stroke)

Apart from the physical deficits resulting from stroke, depression is an important sequela which can be overlooked. It is said to be more common in dominant anterior lesions. Treatment of choice is probably an SSRI antidepressant. Also, ongoing hypertension or thromboembolic disease needs careful treatment as otherwise progressive cognitive impairment can result.

Subdural haematoma

Peak incidence is between 50 and 60 years. Effects are manifest weeks or months after the initial head injury (which may be trivial). First, a persistent headache and, later, recurrent fluctuations in the level of consciousness are seen. Declining memory is usually obvious in longstanding cases and can be accompanied by neurological signs, such as ipsilateral weakness and hyper-reflexia. Radioactive brain scan is diagnostic in 90 per cent of cases, and CT imaging is helpful. Surgical drainage is often indicated.

Subarachnoid haemorrhage

Subarachnoid haemorrhage accounts for 8 per cent of strokes and has a high psychiatric morbidity. In addition to the early confusional state, personality change and anxiety are common. Difficulty with attention and concentration rather than a decline in intelligence is seen.

Multiple sclerosis

Multiple sclerosis usually develops after childhood but before the age of 50 years. Women are twice as likely to be affected as men, and there is sometimes a positive family history. Psychiatric features include persistent fatigue and depression. Cognitive decline occurs late in the disease, perhaps with associated euphoria. MRI shows white matter lesions or plaques, and visual evoked potentials and CSF oligoclonal IgG are diagnostic.

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When to refer to experts

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Specialist services differ widely in different treatment settings, and so the following recommendations are merely a guide. Many specialist services welcome informal discussions prior to a referral being made, or where the referrer is in doubt as to the suitability of the patient or the services provided by the specialist team.

Drug problems

Specialist referral is suggested particularly in the following circumstances:
- the patient requests specialist referral
- the patient has features of the dependence syndrome
- the patient has a complicated pattern of polydrug use
- the patient is pregnant
- there is risky drug-using behaviour such as injecting.

Medical referral should be considered in cases of overdose, or if the following complications are suspected: septicaemia, bacterial endocarditis, hepatitis B, tuberculosis, or HIV infection.

Do not forget to involve the GP. Many GPs undertake basic substitute prescribing and are able to provide comprehensive care for their drug-using patients.

Alcohol problems

The following are indicators for specialist referral:
- severe dependence
- history of fits
- history of delirium tremens
- severe concurrent physical or mental illness (including cognitive impairment)
- repeated unsuccessful attempts at outpatient detoxification.

The following are medical emergencies requiring immediate hospital admission:
- delirium tremens
- Wernicke's encephalopathy.

Sexual and relationship problems

Sexual dysfunction and desire disorders

- Referral of the couple is usually preferable, but individuals are accepted.
- Referrals of patients of any age from 16 upwards can be accepted.
- Heterosexual and homosexual individuals and couples can be treated.
- If a couple is referred, it is preferable for the relationship to be of at least a few months' duration.
- Patient (and partner) need to be well motivated for sex therapy.

- Problems of desire, arousal (erection or penetration), and orgasm/ejaculation are appropriate for referral.
- It is better to deal with side effects of drugs (e.g. antidepressants or antipsychotics) before deciding to refer, as this can sometimes obviate the need for referral.
- The presence of organic factors such as diabetes or multiple sclerosis is not a contraindication to referral; neither is the presence of depression, anxiety, or psychosis.

Sexual, marital, and couple therapy

- Be alert to sexual side effects of drugs.
- Both partners should be referred if in a stable relationship.
- The consent of both partners should be obtained prior to referral.
- The presence of organic causes of sexual dysfunction is not a contraindication to referral.
- Referral to a forensic team may be more appropriate in patients with potentially harmful sexual deviations.

Eating disorders

Effective help is best provided by staff who understand eating disorders. Therefore referral when the diagnosis is made is preferable. People with eating disorders find that being treated by someone who does not understand the condition is ineffective and may make the condition worse.

Consider emergency admission to specialized unit for eating disorders or medical ward if:

- BMI is less than 13.5 kg/m^2 especially if more than 25 per cent of body weight has been lost in less than 6 months
- there is proximal myopathy
- there are signs of circulatory failure (heart rate <45 beats/min; blood pressure <70/60 mmHg; pre-gangrenous peripheries; frequent faints)
- there are signs of marrow failure (e.g. petechial haemorrhage)
- there is severe electrolyte imbalance (e.g. potassium <2.5 mmol)
- there is hypoglycaemia.

Forensic patients

Forensic psychiatry overlaps with all other psychiatric specialties. For example, all general psychiatrists will have a significant proportion of individuals with criminal records and antisocial behavioural problems in their case load. From time to time medico-legal reports will be requested on general psychiatric cases. Forensic psychiatrists do not aim to take on the totality of work concerned with difficult patients and medico-legal issues but have access to special treatment services (e.g. maximum security hospitals, medium security units, and prison units). Forensic psychiatrists are also quite used to managing serious behavioural problems, particularly those which present long-term difficulties. Therefore they may actively assist in the treatment of cases within the community.

Sometimes this is done by the forensic team taking over the care of a difficult patient; sometimes it is done by joint working with regular advice being provided to the core workers.

Advice about management, legal problems, services, and the like, can also be sought from forensic psychiatrists without a direct patient referral. Advice may be sought particularly for the following:

- assessments of dangerousness, especially in the presence of multiple risk factors (see p.106), and of mental state at the time of an offence
- management of dangerous behaviour
- advice regarding preparation of medico-legal reports
- advice on the availability and suitability of services
- referrals to specialist treatment services such as maximum security hospitals, medium secure units, prison units, and forensic outreach teams
- technical legal questions.

Neuropsychiatric problems

Specialist neuropsychiatric units usually have a role in the assessment and treatment of the following:

- psychiatric sequelae of head injury, including depression, cognitive deficits, dementia, and specific lobe syndromes
- neurological disorders including Parkinson's disease, Huntington's disease, and motor neuron disorders
- multisystem disorders, such as systemic lupus erythematosus
- prion disorders
- early-onset dementias, including AIDS dementia
- sleep disorders
- epilepsy (refer if epilepsy interacts with a psychiatric disorder or if pseudoseizures are suspected).

Learning disability

- Always refer when in doubt.
- Refer before commencing any long-term drug therapy, particularly neuroleptics.
- Refer to access community support services. Do not refer simply as a means of disposal.

The elderly

- Many old-age psychiatry services have an age cut-off (e.g. age 65 years), but this should not always be followed rigidly.
- Most services will take over the care of patients with pre-senile dementia (onset before age 65).
- Many elderly patients with long-standing functional illness are best managed by their general adult psychiatry team unless they present with new symptoms, such as dementia.

Specialized psychotherapy

All patients referred to a psychiatrist should receive psychological consideration, even if the primary treatment is medication. Selected patients can be referred onwards for specialist assessment and treatment which, in the NHS, usually means psychodynamic, cognitive–behavioural, or systemic (family/couple) therapy. Where referral for specialist psychotherapy is not appropriate, psychotherapists can still contribute to case discussion. The main criteria for patient referral are someone who is motivated to understand his/her difficulties in psychological terms and who can contain his/her anxiety without behaving in unmanageably destructive ways.

Psychodynamic psychotherapy

In considering who might benefit from this kind of therapy, diagnosis is less important than personal characteristics. Thus someone who wishes to address problems in the context of a relationship, who is not aiming for immediate symptom relief, and who can tolerate the relatively unstructured setting necessary for the optimal exploration of personal difficulties might benefit from this approach. There are no absolute contraindications but, in practice, active drug or alcohol misuse, active psychosis, or a significant tendency towards self-harm or violence would preclude treatment in standard NHS facilities. Most people treated have neurotic or personality problems (e.g. depression, anxiety, difficulties with partners, friends, or peers, problems with loss and interdependence), which they inevitably reproduce with the therapist, allowing them to be worked with in a live way. Both individual and group treatments are usually available, with the choice depending on a balance of factors including patient preference.

Cognitive–behavioural therapy (CBT)

The premise behind this therapy is that thoughts, actions, emotions, and physiology influence one another in a cyclical fashion, and that intervening at any point of the cycle can productively disrupt it. Thus depression is characterized by a negative thought pattern about self, the world, and the future, and can be treated by challenging these thoughts, as well as physiologically (by medication) or behaviourally (by a programme of activity). In cognitive therapy, the emphasis is on challenging dysfunctional thinking, although in practice most programmes include a behavioural component. The main criteria for suitability are that the model makes sense to the patient and that s/he is willing to experiment with alternative ways of thinking both in the sessions and between them, as 'homework'.

As with other forms of therapy, the patient has to be able to contain anxiety sufficiently to work within the model. However, the more structured nature of the sessions and their more conscious content render CBT inherently less anxiety-provoking than psychodynamic therapy. CBT has been shown to be effective in depression, anxiety, phobias, and obsessive–compulsive and eating disorders, among others. In addition, some aspects of psychosis are amenable to CBT and, less commonly, the techniques have been used in groups. People with personality disorders

may respond to longer-term, more specialized CBT, although psychodynamic therapy is often the preferred option in these cases.

Family therapy

Unlike most other therapies, useful work can be done in these sessions even when the index patient is too ill to participate fully. This is because resultant shifts in the family system may operate to the patient's (as well as the family's) benefit. Moreover, the more ill the patient, the more the family is entitled to consideration in its own right, especially as family members may be involved in long-term care and support. A great deal can be gained by making a family dynamic assessment early on in treatment, and, in principle, any family that expresses a willingness to work together with a skilled professional in helping their ill member is suitable for referral for family therapy. Family therapy has been shown to be effective in reducing relapse in schizophrenia, as well as in adolescent anorexia nervosa, and as a couple treatment for depression where one partner is affected. In family therapy no clear distinction is made between assessment and therapy; the first session aims to establish a treatment contract and this contract is reviewed regularly. In practice, a typical contract might involve four to six sessions over a 2–3 month period, depending on response.

Case discussion

Psychotherapists can offer discussion of complicated cases, even when these are unlikely to be suitable for psychotherapy. This can happen as a one-off or as part of a regular seminar attended by all members of the multidisciplinary team. In practice, these seminars tend to be offered by psychodynamically oriented therapists, who are trained to think about the dynamics evoked in the team as well as about the individual patient. The patients discussed tend to be the ones who generate most emotion and controversy among those trying to help them and often suffer from a personality disorder in addition to the 'Axis I' diagnosis. Case discussions help the staff to keep track of counter-transference interference with sound judgement and good management.

Chapter 10

Treatments

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Advice on rapid tranquillization is given in Table 10.1. Appendices 4, 5, and 6 contain further information about antipsychotics. Information about management of the side effects of clozapine is given in Appendix 7.

Acute psychosis

A patient with a first episode of schizophrenic psychosis should receive an antipsychotic chosen jointly by the prescriber and the properly informed patient or carer (or both). If this is not possible, an atypical antipsychotic or possibly a low-dose typical antipsychotic should be started. Many believe that atypical drugs are better tolerated than typical drugs. This is true in the short term as they induce less extrapyramidal side effects at normal doses. However, they are not without their own side effects, and this should be taken into account in prescribing. Thus olanzapine might not be first choice in a teenage girl preoccupied with her slim figure, nor risperidone in a young man with doubts about his sexual function. If the first treatment fails, it is important to review compliance and tolerability. If the patient shows poor or no response over 6–8 weeks, despite full compliance, it is better to switch to another drug and to assess over a further 6 weeks.

When a patient with a previous history of schizophrenia experiences a relapse, his/her adherence to treatment should be assessed thoroughly, as well as the possible social and psychological precipitants. If adherence to medication is doubtful, one may continue with the usual drug treatment (in combination with a short-term sedative if required in the acute phase). If adherence is deemed satisfactory, then one should switch to a different antipsychotic (and assess over the following 6 weeks). If 6 weeks of this second antipsychotic treatment proves ineffective, then clozapine should be considered as the next alternative. When the adherence to treatment is poor, it is important to investigate the reasons. Compliance aids and education may be helpful. If the poor compliance is related to poor tolerability, the use of a different drug should be discussed with the patient. Treatment with a depot preparation may be useful for those who, while not opposed to taking medication, are unreliable in taking it.

Although antipsychotics are the mainstay of treatment, it is vital to develop and keep a good relationship with the patient and to discuss the pros and cons of the various medications with him/her. Simple explanations of why particular symptoms occur and why medication helps can be very useful and can facilitate the introduction of cognitive behaviour, which is an important adjunctive treatment.

Acute dystonia

Abrupt onset of muscle spasm hours after commencing an antipsychotic (particularly a typical drug) can be very alarming. It is more common in the young than the old, especially on first exposure to antipsychotics. If it causes respiratory stridor and tongue protrusion, it can induce panic. In the latter case, one should stop the antipsychotic and give procyclidine 5–10 mg or equivalent intramuscularly. One should check for cyanosis, and administer oxygen and transfer to a medical unit as required.

Table 10.1 Acute disturbed or violent behaviour

1	Try non-drug measures Seclusion, talking down, privacy and quiet	
2	Offer oral treatment Haloperidol 5 mg, or Olanzapine 10 mg, or Risperidone 1–2 mg	With or without lorazepam 1–2 mg Repeat every 45–60 minutes Go to step 3 if three doses fail
3	Consider i.m. treatment Lorazepam 1–2 mg, or Midazolam 7.5–15 mg, or Haloperidol 5 mg, or Olanzapine 5–10 mg, or Ziprasidone 10–20 mg, or Aripiprazole 10 mg Promethazine 50 mg i.m. is an alternative in patients who are tolerant to benzodiazepines	Olanzapine should not be combined with benzodiazepines The safety of other atypicals combined with benzodiazepines is unknown. Repeat up to twice at intervals of 30–60 minutes if insufficient effect
4	Consider i.v. treatment Diazepam 10 mg over at least 5 minutes	Repeat after 5–10 minutes if insufficient effects (up to three times)
5	Seek expert advice Amylobarbitone 250 mg i.m. is an option	Very very few episodes of rapid tranquillization should reach this point

Neuroleptic malignant syndrome

Neuroleptic malignant syndrome (NMS) is a rare idiosyncratic reaction to antipsychotics characterized by intense extrapyramidal rigidity and other dystonias, pyrexia, which may be mild, autonomic dysfunction, diaphoresis, and clouding of consciousness. There is substantial overlap with acute lethal catatonia. The incidence of the condition is variously reported as between 0.07 and 2 per cent, probably because of the lack of clear diagnostic criteria and the overlap with other severe extrapyramidal syndromes (Kellam 1990). Associated biochemical and other abnormalities include a grossly elevated creatine phosphokinase, leucocytosis, and a raised erythrocyte sedimentation rate.

NMS has been reported with all antipsychotics, typical and atypical, and is unpredictable, although it tends to be associated with larger doses of high-potency typical antipsychotics. Its reported mortality varies between 12 and 18 per cent, usually as a consequence of autonomic instability (e.g. cardiac arrest) or renal failure due to rhabdomyolysis and myoglobinuria. The mortality may be lower with atypical antipsychotics.

Table 10.2 Algorithm for the treatment of neuroleptic malignant syndrome

Transfer to acute medical ward or intensive care unit
Monitor ECG, blood pressure, and renal status
↓
Cessation of neuroleptics
↓
Bromocriptine 5–10 mg orally three times daily
↓
(if unable to swallow)
Apomorphine infusion 1 mg/h s.c.
↓
(no response)
Dantrolene sodium 50 mg twice daily maximum for 3 days

Treatment of neuroleptic malignant syndrome (Table 10.2)

Ideally, all patients suspected of having NMS should be transferred to a medical intensive care facility. Immediate withdrawal of antipsychotics usually produces rapid resolution in patients identified early. A dopamine agonist such as oral bromocriptine or subcutaneous apomorphine is also recommended, and sometimes dantrolene is given intravenously to relax peripheral muscle. Full medical supportive measures to maintain hydration electrolyte status and renal function should be available. In established cases these measures should lead to a resolution over about 10 days.

Treatment of the remaining psychiatric problems

If the patient's psychiatric condition still demands treatment, ECT may be the safest option. However, this should be deferred until after the episode as the anaesthetic risk is increased with autonomic dysfunction. A 'drug holiday' of 2 weeks is certainly recommended and diminishes the chance of recurrence on re-challenge. Re-challenge is best with a lower-potency antipsychotic of a different chemical class (e.g. quetiapine or clozapine). Patients need daily physical monitoring of blood pressure, consciousness, and temperature and creatinine phosphokinase estimations during re-challenge. About one in six patients will suffer a recurrence after a re-challenge.

Further reading

Kellam (1990) The (frequently) neuroleptic (potentially) malignant syndrome. *Br J Psychiatry* **157**: 169–73.

Mania and catatonia

The first episode of mania or hypomania is best treated with an antipsychotic (olanzapine, risperidone, quetiapine, or a typical agent). When a diagnosis of bipolar disorder has already been made, mania should be treated by starting or optimizing a mood stabilizer and starting an antipsychotic. Mood stabilizers are lithium (target plasma concentrations 0.6–1.0 mmol/l), sodium valproate (target plasma concentrations 50–100 mg/l), or carbamazepine (target plasma concentrations 8–12 mg/l). If the behavioural disturbance requires sedation, one may initiate benzodiazepine (lorazepam up to 4 mg/day or clonazepam up to 2 mg/day) but should remember to withdraw it after resolution of the acute symptoms. Antidepressants should be discontinued in all patients.

In severely disturbed patients, or patients refusing medication, or in a manic emergency, parenteral treatment with antipsychotics or benzodiazepines may be useful. Atypical drugs should be considered first because of their better short-term adverse effect profile compared with typical drugs; the doses should not be escalated simply to achieve a sedative effect.

ECT may very occasionally be considered. This should be bilateral because of the need for a rapid response. The disturbance usually abates after one or two applications.

Catatonia is rarely seen in developed countries now, but it is important to distinguish it from NMS and manic or depressive stupor (see p.91). Catatonia may be characterized by waxy flexibility, negativism, automatic obedience, and a 'wooden' affect. Treatment of the catatonia is of the underlying condition, but in persistent or distressing states benzodiazepines or even ECT may be tried.

Severe depression

Antidepressant treatment

Antidepressants are the mainstay of pharmacological treatment. Their effectiveness should be assessed 4–6 weeks after having reached the therapeutic dose. In cases of poor tolerability or inadequate response to the maximum tolerable dose, switch to a different antidepressant. When switching between antidepressants, abrupt withdrawal should be avoided and cross-tapering should be used. All antidepressants (but especially paroxetine and venlafaxine) have the potential to cause withdrawal phenomena when stopped abruptly; therefore they should always be withdrawn slowly, preferably over 4 weeks. Common symptoms of antidepressant discontinuation are dizziness, electric shock sensations, anxiety and agitation, insomnia, influenza-like symptoms, diarrhoea and abdominal spasms, paraesthesia, mood swings, nausea, and low mood. If withdrawal symptoms occur, slow the rate of drug withdrawal and return to the last dose tolerated by the patient. If the drug has been stopped, give reassurance; symptoms rarely last more than 1–2 weeks.

If the patient does not respond to a second antidepressant, check compliance and review the history for social factors which may be

aggravating the patient's condition. An atypical antipsychotic may be added, especially if there are psychotic symptoms.

Levels of inpatient supervision for a suicidal patient

When a suicidal patient is admitted, the admitting doctor should discuss the level of supervision with a senior nurse. The options are as follows.

1. **Close observation** The patient is always in sight of the supervising nurse. This is the normal practice when a depressed patient is admitted with high suicide risk. Usually the risk abates within a few days, but the level of risk needs to be assessed daily.
2. **Continuous supervision** The patient is always within reach of a nurse. This is used when the patient is at immediate risk from self-destructive, including bulimic, behaviour.
3. **Routine nursing care**

Assessment of other physical risk

Weight loss is common and, unless severe, is not a cause for concern. However, dehydration is always an indication for admission and institution of a fluid balance chart with assessment of electrolytes. Skilled nursing persuades many patients to drink, but if this fails other action is needed, including very occasionally intravenous rehydration or emergency ECT.

Prescribing during pregnancy and breastfeeding

Clinicians must help the patient to weigh up the risks of drug treatment against the high risk of relapse of psychotic and affective disorders. A detailed discussion with the patient should always occur, preferably before conception, and all decisions should be well documented. As a general principle, the lowest effective dose should be used, with close monitoring of both the mental state and fetal development.

Most of the available data relate to older drugs, but data are emerging for newer drugs, so that the most recent advice should always be sought. Among the **antidepressants**, tricyclics have a good safety record but SSRIs are now widely prescribed during pregnancy. They are not thought to be associated with obstetric complications or fetal malformations but can be associated with a withdrawal syndrome in neonates. Among the **antipsychotics**, most experience is with chlorpromazine and trifluoperazine and they are commonly recommended. Olanzapine is also extensively used, but gestational diabetes may be more common with it and some other atypical drugs. Depot antipsychotics are not advisable. No **mood stabilizer** is clearly safe, and carbamazepine and sodium valproate are best avoided during pregnancy. Women on lithium should undergo level 2 ultrasound screening for Ebstein's anomaly at 6 and 18 weeks. If valproate or carbamazepine cannot be avoided, the fetus may be at risk of neural tube defects and the mother should take folate supplements, preferably starting before conception; this is perhaps a wise precaution with atypical drugs also.

Breastfeeding

In general, women with psychosis during the postpartum should be discouraged from breastfeeding. Breastfeeding should also be avoided if the infant has impaired renal, liver, cardiovascular, or neurological functions. Although sodium valproate and carbamazepine do not appear to put the baby at excessive risk, lithium concentrates in breast milk. Tricyclics cause sedation in the baby, and breastfeeding is contraindicated if a woman is taking MAOIs. SSRIs, in average doses, do not cause side effects to the baby and are the antidepressants of choice in a breastfeeding woman.

Electroconvulsive therapy

ECT is probably the most powerful treatment available for severe depression but is now used much less frequently than formerly. Because it involves seizure induction and is associated with cognitive side effects (e.g. retrograde amnesia), it should only be used when absolutely necessary. Many patients (and their relatives) are wary of it, and great care should be taken in explaining the procedure, treatment aims, and side effects; written information should also be made available. One should be very cautious about compulsory ECT, but when it is unavoidable the relevant legal powers to administer it will need to be invoked beforehand.

Detailed information about ECT can be found in the most recent edition of the *The ECT Handbook* (Royal College of Psychiatrists 2005). Every hospital should have a local policy for ECT with which you should be familiar. You should also be familiar with the relevant Mental Health legislation. The Royal College of Psychiatrists have also established an ECT Accreditation Service (ECTAS) (www.rcpsych.ac.uk/cru/ECTAS.htm) to help improve and standardize practice.

Indications

The National Institute for Health and Clinical Excellence (NICE) guidance on ECT (www.nice.org.uk/page.aspx?o=68307) recommends that it be restricted to severe depressive illness, catatonia, and prolonged or severe mania.

Depressive illnesses

ECT is effective for severe depression but is only necessary in a small proportion of patients, who are usually treatment resistant. It is particularly useful when symptoms include psychomotor retardation and psychotic features such as delusions and/or hallucinations. It can be life-saving if the patient is very acutely suicidal or in rare instances where s/he fails to maintain adequate nutrition or hydration. Other indications include patient preference, a past history of response to ECT, the need for a rapid response to treatment, and if the risks of other treatments exceed those for ECT. Old age psychiatrists may recommend its use in the depressed elderly who have not responded to drug treatments or have suffered unpleasant side effects. Remission rates in clinical trials are 60–70 per cent.

Manic illness

ECT is occasionally used for mania. Indications include the need for a speedy therapeutic response, as a safe alternative to high-dose medications, or if patients have drug-resistant or 'rapid cycling' mania.

Schizophrenia

There are very few indications for ECT in schizophrenia. Very rarely it may be used when psychotic symptoms are associated with abnormal motor activity such as catatonic excitement or immobility. It may be considered if the patient cannot tolerate medications or has failed to respond to adequate doses of antipsychotics including clozapine.

Other conditions

ECT can occasionally be useful in postpartum psychoses, NMS, and catatonia.

Contraindications

Although there are no absolute contraindications to ECT, coexisting medical illnesses must be treated. Close liaison between the psychiatrist, anaesthetist, and physicians is necessary. Pregnancy and old age are not contraindications to ECT, but any contraindications to general anaesthesia will apply; 'high-risk' cases with recent myocardial infarction, cerebrovascular accident, or raised intracranial pressure should be assessed on an individual basis in consultation with the anaesthetist. Those with known cardiac disease will need assessment by a physician or cardiologist prior to ECT. ECG monitoring is necessary during ECT administration, and staff should be adequately trained in cardiopulmonary resuscitation and management of arrhythmias. Following myocardial infarction, ECT should be delayed as long as possible and is probably safer after 3 months.

Side effects

The mortality associated with ECT is similar to that for minor surgical procedures (approximately 2 per 100 000 treatments). The most common side effects include headache, confusion, and memory impairment. Anterograde amnesia is usually temporary but defects in retrograde memory can be more long-lasting; for example, patients may complain that they cannot remember their wedding. Rarer side effects include prolonged seizures and physical complications such as ruptured bladder or aspiration pneumonia. While bilateral application of ECT is currently the most common means of inducing a seizure, right unilateral ECT can be used if cognitive side effects are troublesome.

Preparation

As for any patient having a general anaesthetic, a full physical examination and history are required. In addition to baseline blood electrolytes and full blood count, the need for other tests such as a sickle cell screen should be considered. An ECG and chest radiograph will be needed if there is a history of cardiac disease or other physical illness, and the anaesthetist should be notified of any significant physical illnesses.

Patients should be fasted for at least 6 hours before the procedure. As benzodiazepines are powerful anticonvulsants, acute dosing should be avoided immediately prior to ECT, and even short-acting benzodiazepine hypnotics may be present in significant quantities the morning after. However, patients who are chronic benzodiazepine users have a lower threshold for seizure during benzodiazepine withdrawal and abrupt reductions in dosage are best avoided during ECT. Similarly, anticonvulsants

raise the seizure threshold and higher stimulus energies may be needed for treatment. Anticonvulsants prescribed for mood stabilization can be continued during ECT. Antipsychotics tend to be proconvulsant.

All patients should be accompanied to the ECT suite by a member of staff whom s/he trusts. Staff should have completed a pre-ECT checklist, detailing general observations including removal of jewellery and dentures as appropriate. You should have access to the case notes and current and past drug prescription chart. The consultant's prescription for ECT, which documents indications for ECT, relevant past medical history, past treatments, legal status, and past psychiatric history, should also be available. If the patient has had ECT before, previous prescription charts can give useful information about the stimulus charge required. Fully informed consent must be obtained and documented, or the relevant legal documents pertinent to the administration of ECT must be available for scrutiny.

Administration

The procedures must be carried out meticulously. The doctor should be familiar with the ECT machine and should be supervised by a senior clinician. Most modern machines deliver brief pulses and have an EEG monitoring facility. The EEG is now the definitive method for measuring seizure duration and can also provide useful information about seizure quality. Electrode placement can be either bilateral or right unilateral. Bilateral placement is currently more routinely used, but unilateral placement is associated with less memory impairment. However, bilateral ECT may be preferable where a rapid response is required. At the first session the seizure threshold (ST) may be determined. This is the stimulus charge required to induce a seizure lasting 25 s on EEG monitoring. Thereafter suprathreshold charges are used (e.g. 1.5 × ST for bilateral ECT and 2.5 × ST for unilateral ECT) and doses may be titrated as the ST can rise during an ECT course. High-dose unilateral ECT (i.e. 4–6 × ST) may be as effective as bilateral ECT while having a better side-effect profile.

Prolonged seizures are those that last for 2 minutes or more and should be terminated either with further induction agent or intravenous diazepam. The number of treatments will be determined by the clinical progress, which should be formally documented in case notes. A common policy is twice weekly administration for 6–12 treatments.

Deliberate self-harm

Assess the patient's mental state in the light of the social environment and coping skills (see p.29).

- Treatment of the patient's physical condition takes precedence (remember the liver toxicity of acetaminophen).
- Suicide and risk of repetition cannot be assessed in a drowsy patient.
- In patients with low repetition risk and no mental illness, the principles of **crisis intervention** apply: 'understand' the attempt; mobilize resources; consider a 'non-DSH' contract; discharge preferably to relatives; inform GP; appointment with DSH liaison or alcohol/drugs services team.

- High-risk patients: most will be mentally ill. Management depends on the community resources available (e.g. supportive relatives, GP, community psychiatric nurse). In case of unacceptable risk, consider admission, compulsorily if necessary.
- Frequent repeaters: same principles apply; long-term management plan is vital to avoid counterproductive admissions.
- Risk can never be excluded completely; careful note-taking and interdisciplinary communication are vital for your patient's health and your own protection.

Opiate overdose causes varying degrees of coma, respiratory depression, and pinpoint pupils. The short-acting opiate antagonist naloxone is indicated if there is coma or bradypnoea. Dosage is 0.8–2 mg repeated at intervals of 2–3 minutes to a maximum of 10 mg if respiratory function does not improve. It is available in preloaded syringes. Because of its short action it may be necessary to set up a naloxone infusion which is adjusted according to response. This may occur in patients who have overdosed on methadone as this has a long half-life. In severe cases mechanical ventilation may be necessary.

Following the administration of naloxone, patients will experience acute withdrawal. It is important to continue to observe them for 24 hours, but commonly craving for drugs will lead them to discharge themselves.

If **methadone overdose** is reported but there are as yet no signs of respiratory depression, activated charcoal should be given and the patient observed closely. Inducing patients to vomit is not recommended because of the risk of rapid onset of CNS depression and unconsciousness which could lead to choking.

Cocaine overdose is characterized by cardiovascular complications including arrhythmias, cardiac ischaemia, myocarditis, cardiomyopathy, and hypertension. Seizures and hyperpyrexias also occur. Treatment is supportive and patients need medical help as soon as possible.

Alcohol dependence

The alcohol withdrawal syndrome

Individuals will only experience symptoms of alcohol withdrawal if they are physically dependent on it. Thus some heavy drinkers experience no withdrawal symptoms, whereas others show evidence of mild or moderate withdrawal and a few will develop a life-threatening disturbance.

Symptoms of alcohol withdrawal start approximately 3–6 hours after the last drink. Early symptoms include tremor, sweats, nausea, insomnia, and anxiety. Transient auditory hallucinations in clear consciousness may occur. There is a risk of alcohol withdrawal seizures of between 10 and 60 hours; these generalized (grand mal) seizures are often associated with hypoglycaemia, hypokalaemia, hypomagnesaemia, and concurrent epilepsy. Most alcohol withdrawal syndromes resolve within 72 hours of drinking cessation. The more severe the withdrawal, the longer the duration. A few patients go on to develop delirium tremens (DTs) around 72 hours after the last drink. Symptoms include severe clouding of

consciousness, confusion, hallucinations in any modality, tremor, fear, paranoid delusions, restlessness, and agitation. The condition usually lasts for 3–5 days, with gradual resolution. Predisposing factors include hypoglycaemia, hypokalaemia, hypocalcaemia, and intercurrent infection.

Delirium tremens and Wernicke's encephalopathy are medical emergencies requiring immediate hospital admission.

Treatment of alcohol withdrawal

Most patients can be detoxified safely and effectively in the community. Indications for inpatient detoxification include severe dependence, a history of delirium tremens or alcohol withdrawal seizures, coexistent medical problems, an unsupportive home environment, and a previously failed community detoxification. All patients need general support and a proportion will need pharmacotherapy for the withdrawal symptoms. Benzodiazepines are the treatment of choice, and individual doctors should become familiar with one drug of this class. Because of the great range in the severity of the alcohol withdrawal syndrome, a range of drug doses is indicated. A mild to moderate withdrawal syndrome in an outpatient should respond to chlordiazepoxide (Librium) 5–10 mg three or four times daily. A moderate withdrawal syndrome may require a dose of the order of 15–20 mg three or four times daily. Community and outpatient detoxifications should last for approximately a week. In the inpatient setting, chlordiazepoxide is prescribed according to a flexible regime over the first 48–72 hours, with dosage titrated against the severity of withdrawal symptoms. Higher doses are usually required in the inpatient setting, for example chlordiazepoxide 40–60 mg three or four times daily, reducing over 5 days. However, a longer regime may be required in the case of patients who have delirium tremens or a history of delirium tremens.

Chlormethiazole (Heminevrin) still has a role in the inpatient setting but is contraindicated for community detoxification because of its potential for dependence.

Appropriate treatment as described above should prevent the development of alcohol withdrawal seizures, and anticonvulsants are not routinely indicated. However, carbamazepine may be considered if there is a history of seizures during any previous withdrawal episodes or a history of untreated epilepsy.

Because of the risk of Wernicke's encephalopathy in these patients, prophylactic thiamine (vitamin B) supplementation is recommended. Thiamine may be taken orally, but absorption is poor. Prophylactic treatment for Wernicke's encephalopathy should be one pair i.m./i.v. ampoules of high-potency B-complex vitamins (Pabrinex) daily for 3–5 days (or thiamine 200–300 mg intramuscularly daily if Pabrinex is unavailable). Parenteral vitamin supplements should only be administered if suitable resuscitation facilities are immediately available.

Delirium tremens

Clinical features

Alcohol withdrawal phenomena: rapid onset of hallucinations, fear, disorientation and confusion, tremor, tachycardia, fever, overactivity, and clamminess (not always the full house!).

Differential diagnosis
Delirium due to another cause.

Management
The full-blown syndrome should be managed on the medical unit (mortality >5 per cent). Give adequate sedation (chlordiazepoxide 40 mg four times daily) and fluid replacement. Administer vitamins (thiamine) as a prophylactic. Beware withdrawal seizures.

Wernicke's encephalopathy

Clinical features
The classic picture is of acute onset of nystagmus, gaze palsies, gait ataxia, and confusional state due to thiamine deficiency, but not all patients will show the full picture. It is most commonly seen in alcoholics, but may also occur in malnutrition and prolonged vomiting (including eating disorders).

Differential diagnosis
Infective or metabolic encephalopathy, hydrocephalus, tumour, posterior circulation infarction, or haemorrhage.

Management
Treatment should be given as soon as the diagnosis is entertained, preferably intravenously. This should be at least two pairs i.m./i.v. ampoules high-potency B-complex vitamins daily for 2 days. If symptoms respond, continue one pair ampoules daily for 5 days or as long as improvement continues.

Illicit drug misuse

The treatment of illicit drug misuse is guided by two fundamental practices.

First, obtain as good a drug history as possible to determine whether the pattern of drug misuse constitutes:

- harmful use
- dependent use (compulsion to use/craving, salience of drug use, narrowing of repertoire, increased (or decreased) tolerance, continued use despite harm, withdrawal symptoms and reinstatement after abstinence)
- polysubstance misuse.

Secondly, conduct a good physical examination; polysubstance misuse is associated with multiple physical complications arising directly from drug use and indirectly from injection-related injury, deep vein thrombosis, viral infection, malnutrition, etc.

Opiates

Opiates are drugs which principally interact with the mu opioid receptor, which is distributed in the brain, spinal cord, and gastrointestinal system. They are used clinically to control extreme distress (e.g. myocardial infarction) and extreme pain, and are misused as they produce euphoria.

A wide range of opiates may be misused, and symptoms of intoxication and withdrawal vary in timing according to the plasma half-life (heroin < methadone < buprenorphine) and route of administration (oral > smoked (chased) > injected).

Opiate intoxication

Excess opiates progressively produce difficulty in concentrating, confusion, intense sleepiness ('gouching' out), impaired rousability, respiratory depression, cyanosis, and coma. Opiate overdose is a major cause of death because of unpredictable variations in dose. The triad of unrousability, cyanosis, and constricted pupils is virtually diagnostic of opiate overdose. Treatment is with the opioid antagonist naloxone 0.4 mg intravenously or intramuscularly and transfer of the patient to hospital as an emergency, even if apparently fully recovered. Naloxone has a short half-life (20 minutes) and can wear off before the opiate does.

Opiate withdrawal

The effects of withdrawal from opiates are due to unopposed activity by various neurotransmitter systems involved in the acute stress response which have adapted to the presence of opiates. The symptoms can be predicted from the effects of unopposed high levels of central noradrenergic activity in the locus coeruleus and peripheral sympathetic autonomic activity. Onset depends upon the opiate used and the route administered, with onset between 12 and 72 hours, peak between 3 and 7 days, and milder effects such as sleep disturbance persisting for months.

The symptoms are:

- dysphoria
- tachycardia and elevated blood pressure
- pupillary dilation
- rhinorrhoea
- lacrymation
- piloerection (goose-pimples)
- nausea and vomiting
- abdominal cramps and diarrhoea
- skeletal muscle cramp and bone pain
- anxiety.

Craving for opiates and opiate-seeking behaviour are often the most marked withdrawal symptoms.

Although markedly unpleasant, the withdrawal syndrome is not directly physically dangerous, except in neonates where it can produce seizures. Although it may be expected to vary with the dose of opiate, the severity of opiate withdrawal syndrome is also susceptible to other factors such as the physical and social environment. Withdrawal of opiates can reveal masked underlying symptoms such as pain.

Symptomatic relief with non-opiate medication

This is an option which can be offered by any doctor when a patient presents in withdrawal. Medication to consider includes:

- metoclopramide (nausea and vomiting)
- mebeverine (constipation)
- zopiclone, zolpidem (sleep disturbance)

These are prescribed in normal doses for the duration of the withdrawal period.

Benzodiazepines have been used in opiate withdrawal to aid sleep, muscle spasm, and anxiety. However, given their widespread misuse, their use should be restricted to the short term under strictly controlled conditions. Increasingly, zopiclone and zolpidem are also being implicated in abuse and dependence.

Lofexidine

Lofexidine is licensed for the management of opioid withdrawal symptoms. It is a centrally acting α_2-adrenergic agonist which reduces norepinehrine release from the locus coereleus. It is important to monitor blood pressure and pulse at baseline and during treatment. Recommended doses are 0.4–0.6 mg two to four times daily initially, increased if necessary to control withdrawal symptoms to a maximum total daily dose of 2.4 mg. Treatment is over 7–10 days, followed by a gradual withdrawal over 2–4 days.

Opiate replacement

Methadone and buprenorphine are licensed to assist withdrawal from opiates. Initially the patient should be stabilized on a dose sufficient to control withdrawal symptoms. The dose is then tapered according to an exponential decay curve (i.e. larger decrements initially). In practice, the time over which this is done varies with the situation, from reduction over 10 days in the inpatient setting to much slower reduction for outpatients.

Opiates: basic substitute prescribing

Substitute prescribing of opiates provides opportunities for several types of treatment:

- short-term medically assisted withdrawal (see above)
- longer-term (months) outpatient effort to achieve abstinence
- maintenance treatment in which the aim does not include abstinence except in the much longer term (years).

The treatment aims of maintenance are harm minimization: reduction in frequency of injecting; reduction in amount of illicit drug use; reduction in crime; social and psychological stabilization (see section on harm reduction).

The crucial issue in substitute prescribing is to establish that the patient is already opiate dependent. Methods include:

- history-taking
- detection of heroin in several urine samples
- inspection of injection sites in an intravenous user
- observation of withdrawal symptoms.

Two opiates are licensed and commonly used for opiate replacement.

- Methadone is an orally available full opioid agonist which is usually administered as a weak solution at 1 mg/ml (hence not injectable). Typical doses are 60–120 mg/day.
- Buprenorphine is an orally available high-affinity partial opioid agonist which is given as a sublingual tablet (can be illicitly injected). This has the significant advantage of being much safer in overdose (reduced rate of respiratory depression). Typical doses are 4–16 mg/day.

The initial dose can be estimated from the history of heroin consumption, but it is usual to start with a safe dose administered in a setting where response can be assessed later that day or the following day, and gradually titrate the dose upwards. If the aim is opioid withdrawal, the dose will be the lowest which controls withdrawal symptoms; if it is maintenance, the dose may be considerably higher since higher doses are associated with better outcomes.

In the UK, these opiates are prescribed from a hospital on a pink prescription which allows for multiple dispensing dates. It should usually be prescribed for dispensing on a daily basis. The prescription needs to contain the type of opiate, the daily dose and the total amount in words and figures, the frequency of dispensing, and the start date. For example: Methadone Mixture 1 mg/ml DTF 40 mg (forty) daily for 14 days. Dispense daily, but for two days on Saturdays. Start on 1st July 2008. Total dose 560 mg (five hundred and sixty).

The conditions under which the prescription is offered should be clearly agreed between the patient and the prescriber at the outset. Issues to be agreed include length of prescription, frequency with which the prescriber will see the patient, lack of acceptability of aggression, threats, or actual violence, alcohol consumption, urine testing in which heroin and methadone use can be distinguished, whether continued evidence of illicit drug use is acceptable, and other treatment to be offered in addition to prescribing. It is also good practice to identify, at the outset, the targets which it is anticipated the treatment offered will help the patient to achieve, and future dates at which treatment will be reviewed.

Benzodiazepines

The benzodiazepine group of drugs and newer non-benzodiazepine sedatives both target a modulatory benzodiazepine site on the GABA receptor complex, prolonging its inhibitory action. They include drugs with a wide range of half-lives which affect the pattern and severity of onset and withdrawal. Examples are as follows.

Short-acting drugs:
- triazolam
- temazepam

Intermediate-acting drugs
- oxazepam
- nitrazepam
- clonazepam.

Long-acting drugs:
- diazepam
- flunitrazepam
- clobazam.

Non-benzodiazepine (short-acting):
- zolpidiem
- zaleplon
- zopiclone.

If used as prescribed for long periods, these may produce 'normal dose' dependence and produce withdrawal symptoms on cessation. These drugs are most often misused in combination with other drugs such as stimulants (to relieve anxiety) or alcohol (to enhance alcohol effects).

Benzodiazepine intoxication

Overdose symptoms include confusion, loss of consciousness, slowing of reflexes, incoordination, 'paradoxical' disinhibition, respiratory depression, and unconsciousness. While conventionally viewed as safe in overdose (compared with barbiturates, which this class of drug replaced), the sedative effects are increased by opiates and alcohol. Overdose is a medical emergency and the patient should be transferred to hospital. The specific antagonist flumazenil is used to reverse overdose (1–3 mg intravenously), ideally by controlled infusion as it may precipitate seizures.

Benzodiazepine withdrawal

In clinical practice, the most likely benzodiazepines to be regularly used, and abused, are temazepam and diazepam. Withdrawal symptoms will have an insidious onset in this situation and may occur days after the last dose of diazepam. Symptoms are due to reduced activity of the GABA complex and excess glutamatergic drive. They consist of general symptoms of anxiety:

- anxiety
- tachycardia
- tachypnoea
- nausea
- abdominal cramp
- skeletal muscle cramp
- diarrhoea
- tremor
- perceptual distortion
- seizures.

The symptoms can be more subtle and difficult to distinguish from other conditions such as anxiety disorders and opiate withdrawal. However, benzodiazepine withdrawal carries a greater physical danger because of the risk of seizures.

Stabilization onto diazepam and gradual tapering of the dose will control withdrawal symptoms. As with opiates, the time over which the tapering occurs is shorter and more rigidly determined in the inpatient setting (10–21 days). Reduction in outpatients is more likely to take place over the course of several weeks and to involve the patient in determining the rate of reduction (see section on substitute prescribing).

In patients with an established history of seizures, a covering dose of an antiepileptic such as carbamazepine may aid a planned withdrawal.

Benzodiazepines: basic substitute prescribing

In contrast with opiate maintenance, the evidence base for benzodiazepine maintenance in the population of drug misusers is scant; particular problems are diversion, dose escalation, inability to monitor illicit use, and minimal harm reduction. Because of its long half-life diazepam is usually chosen as a substitute to replace illicit temazepam and other

benzodiazepines. Decisions are made according to local practice, the local population of drug misusers, and individual clinical assessment.

Diazepam can currently be prescribed in the UK only on yellow single-dispensing prescriptions. Arranging supervised daily dispensing, although desirable in many cases, is often inconvenient or impossible. As with methadone, agreement on the conditions of treatment, criteria for review, and frequency of review must be clear at the outset.

Cocaine, amphetamines, and other stimulant drugs

The stimulants include cocaine, usually smoked 'crack' cocaine or snorted powder, but occasionally injected, amphetamines (including methamphetamine), and 3,4-methylenedioxymethamphetamine (MDMA or ecstasy). All stimulate release of monoamines, principally dopamine, to produce euphoria.

Stimulant-induced confusion and anxiety states

Stimulants can be used repeatedly until exhaustion, physical or financial, supervenes. However, their use can cause acute effects which can be severe enough to present to the general psychiatrist. These states are commonly of euphoria or anxiety, but may proceed to more severe symptoms such as paranoid ideation leading to violent and aggressive behaviour and auditory or visual hallucinations. Insight is usually retained or only transiently impaired. Management involves calming and reassuring the patient until the effects wear off. Occasionally, oral diazepam (10–20mg) may be needed and in severe cases antipsychotic medication is required. If symptoms persist, they may become a drug-induced psychosis requiring general psychiatric management.

Stimulant withdrawal

When stopped abruptly, stimulants produce a brief physical withdrawal syndrome or 'crash', marked by exhaustion, depressed mood, and motivation. Trials of various medications have found these to be of little value, and most patients just need advice regarding the likely symptoms, reassurance that they will pass, and a safe place to get through this period. Some patients may become acutely suicidal and will require hospital admission and close observation.

Substitute prescribing of stimulant drugs is not recommended and should be left for specialist treatment services. However, stimulant drugs, like opiates, may be injected and advice on harm reduction may be appropriate (see section on harm reduction).

Hallucinogens

Drugs such as LSD or psilocybin (magic mushrooms) do not produce a physical withdrawal syndrome and can be stopped abruptly. There is no role for substitute prescribing. One crucial exception is ketamine (Special K), a dissociative anaesthetic producing psychedelic effects which may produce dependence. Some people experience severe psychological distress during or after use of hallucinogens and may need symptomatic treatment (such as a brief course of benzodiazepines to reduce anxiety), and a safe place to be while the experience passes.

Harm reduction

This is a pragmatic approach to the management of drug users, developed following the discovery of increased HIV transmission in the intravenous drug using population. A practical reduction in the harms of drug use takes priority over the idealized reduction of drug use itself. It sets out a hierarchy of treatment goals, with abstinence being the ideal outcome but with achievable intermediate goals, for example to reduce intravenous drug use and transfer to oral drug use or to move from risky injecting where needles are being shared to safer injecting using clean injecting equipment.

Basic harm reduction advice should be available whenever a drug user presents to a service and should include education about the following.

- Safe injecting techniques, including not sharing or reusing needles, skin cleaning, and advice about the danger of some injecting sites, particularly groin and femoral.
- Advice on how to obtain clean injecting equipment. This will depend on the area but may be from a local drugs agency or a pharmacy needle-exchange scheme.
- Advice on safer sex. This will include advice on how the virus is transmitted sexually, by vaginal or anal intercourse and less frequently by oral sex, and on the correct use of condoms.
- Advice on the dangers of overdose from opiates. This includes an awareness of problems with losing tolerance after a period of lower drug intake, such as being in prison, and the dangers of new supplies of drug which may have higher purity.
- Advice on the dangers of prescribed and non-prescribed drugs to children. Methadone overdoses in children are common, and any amount may be dangerous and need hospital treatment.
- Hepatitis B immunization for non-immune individuals; HIV and hepatitis testing with appropriate pre- and post-test counselling.
- Prescription of oral substitute drugs (see sections on basic substitute prescribing).

Eating disorders

Anorexia nervosa

Outpatient psychotherapy is the recommended treatment for the majority of people with anorexia nervosa Specialist psychotherapies such as cognitive analytical therapy, cognitive–behavioural therapy, family therapy, interpersonal therapy, or modified dynamic therapy are more effective than non-specialist or dietetic treatment. Frequently, the therapy has to be continued long term. It is important that this is supplemented by regular medical monitoring. It is helpful to have the patient's family involved in treatment. Parental counselling is as effective and more acceptable to the family than conjoint family therapy.

Inpatient treatment is necessary for those with severe weight loss and high medical risk. Staff with expertise in management of eating disorders can provide a judicious mixture of psychotherapy and nutritional support. In extreme circumstances people may be detained under the Mental Health Act.

Bulimia nervosa

Cognitive behavioural therapy (16–20 sessions) is the treatment of choice for the majority of patients with bulimia nervosa. Low-intensity interventions such as self-help with guidance, group treatment, or antidepressant therapy may be useful as a first step in treatment for a proportion of cases, especially those with less severe symptoms. Patients with comorbid personality disorders or with additional physical morbidity, such as diabetes mellitus, may need long-term psychotherapy, inpatient care, or day care.

Treatment must address the psychological aspects of anorexia and bulimia nervosa as well as the eating behaviour. Refeeding alone may be successful in short-term weight restoration but is usually not effective in the long term.

Investigations recommended for eating disorders on initial assessment

- Full blood count (cells reduced: white cell count > red blood cells > platelets)
- Urea and electrolytes (low potassium, magnesium, calcium, and phosphate; high bicarbonate)
- Liver function test (all enzymes raised, severe starvation) and protein (decrease rare but sign of poor prognosis)
- Electrocardiogram (QT lengthening, U wave).

Somatization

Management has several purposes: first, to engage the patient in some form of dialogue; secondly, to reduce further doctor visits and medical investigations: thirdly, if possible, to treat any underlying psychological disorder. It is essential that the patient feels understood; listen to the whole history of the symptoms and their impact. You are not taking a history for diagnostic purposes, but so that the patient feels that you have listened and understood his/her predicament and suffering.

Supportive psychotherapy involves seeing the patient regularly, but not in response to symptoms. Rather than saying 'Come and see me when you feel bad', say 'Come every month anyway'. Each session usually involves listening to some account of the symptoms and their impact, even if you can do nothing about them. It is useful to split the session in two, spending the first half talking about symptoms and health, and then allowing the patient to set another agenda incorporating coping strategies.

More specific techniques, usually following cognitive–behavioural principles, are valuable. These usually involve some combination of cognitive work, looking at explanations for symptoms, generating alternative explanations, and examining the links between sleep, mood, illness fears and symptoms. This may be followed by some form of activity management programme with the intention of reducing the link between the experience of symptoms and some maladaptive behaviour pattern (such as going to bed). It is useful to be able to give sensible explanations for symptoms so that patients have an understanding of why they experience symptoms and do not feel that you believe their symptoms are imaginary.

Explaining the role of muscle tension in headache or chest pain, anxiety in palpitations, poor sleep and daytime fatigue, inactivity in muscle pain, and hyperventilation in breathlessness and chest pain can all be useful.

Symptom checklists may be useful both to monitor progress and, if planning to try an antidepressant, to check that any reported side effects really are new. The guiding principle is to empower patients to take back responsibility for their illness and recovery (and not rely on doctors, drugs, surgical procedures, etc), but without harbouring any guilt or blame for becoming ill in the first place. This is harder than it sounds.

Things not to do

If the patient has a specific illness belief ('candida', 'ME', 'chronic allergy'), do not question this even if there is no corroborating medical evidence. Do not dispute the condition by saying 'This illness doesn't exist!' Instead, accept the label and move on to 'How can we help you live with the symptoms/distress?' or 'How can we help you reduce your pain/disability?' Never attempt to switch the patient from a wholly physical to a solely psychological model. This is both inappropriate and largely impossible. Once you have checked that basic investigations have been performed (such as routine biochemical/haematological screen and thyroid function tests), do not refer for more specialist opinions or tests unless some new indication, suggestive of a physical cause, comes along.

Pharmacological management

Depression and anxiety are often present and need treatment. There is some evidence that low-dose tricyclics can be effective where pain and sleep problems coexist. Many patients are reluctant to take antidepressants, but may accept them on these grounds.

Response to treatment

Most patients with somatization are seen in primary care, are easy to engage with, and respond well to simple treatments. Cognitive–behavioural treatments are successful in those with discrete disorders such as atypical chest pain, chronic fatigue, or low back pain. However, those with long histories, who may fulfil criteria for somatization disorder, have a poor prognosis. Limiting the expectations of a cure and concentrating on maximizing function by 'damage limitation' through support and encouragement may be all that one can achieve.

Sexual disorders

Management of sexual dysfunctions

The general management is best done with both partners (if available) and will include both sexual homework exercises and couple relationship work. If there is no partner or the partner is unavailable, it is still possible to treat the individual, but modifications have to be made to the approach and the prognosis is more uncertain.

Behavioural approaches

The sensate focus technique remains a basic form of 'homework exercise' in most sex therapy. There is a ban on intercourse which is replaced by a form of prolonged foreplay designed to improve communication on sexual matters and to reduce performance anxiety. The couple then progress to genital contact and to specific techniques for each dysfunction. For **premature ejaculation**, Semans' stop–start technique is used, stimulating the erect penis and stopping at the 'point of inevitability' just before ejaculation and then starting the process again. For **delayed ejaculation**, the technique of penile 'superstimulation' is recommended, perhaps with the aid of a vibrator; this is usually more successful if the man can already ejaculate in masturbation rather than if he has a total inability to ejaculate. For **erectile dysfunction**, gradual progression from sensate focus to penetration in the 'woman above' position is recommended, with a progression to physical or pharmacological approaches if necessary (see below). For **anorgasmia**, the couple are asked to practice clitoral stimulation, including the use of vibrators. For **vaginismus**, the use of finger dilatation or of graduated dilators is recommended, followed by a careful progression to intercourse. For **dyspareunia**, the treatment depends on the cause, and gynaecological procedures may be needed. In those without a physical cause, sensate focus, relaxation, different positions for intercourse, and relationship therapy may be useful. For **disorders of sexual desire**, the approach is more variable, depending on the factors contributing to it; it may include couple relationship therapy, individual psychotherapy, post-traumatic counselling, antidepressant treatment, hormone therapy, advice on lifestyle changes, and other measures.

Psychotherapeutic approaches

Psychodynamic therapy for the individual with a dysfunction is used, especially when a 'block' is reached and progress ceases. Short-term dynamic therapy may be used in the course of sex therapy, and longer-term therapy may be given in addition if other indications are present.

Cognitive therapy may be used in cases where there is depression or anxiety to be treated. In those with post-traumatic states (e.g. following rape or sexual abuse) specific post-traumatic counselling may be required.

Relationship therapy is indicated in most cases of dysfunction in couples, especially if there are underlying resentments or tensions. Relationship therapy is very useful in couples in which one partner is more enthusiastic for sex than the other (disorders of desire).

Mechanical or pharmacological treatment

This approach is used mainly in **erectile dysfunction**. Penile rings and vacuum pumps can improve erections, and are acceptable to many couples. Sildenafil (Viagra) is useful for the oral treatment of erectile dysfunction. It requires thorough assessment of the underlying causes, usually in a specialist setting. It is generally used for functional, rather than psychological, erectile dysfunction. It should not be prescribed in patients consuming nitrates. Newer drugs such as tadalafil (Cialis), vardenafil (Levitra), and apomorphine (Uprima) are also available, but

NHS prescriptions are limited. Oral yohimbine can improve the quality of erection as well as increasing sexual drive, but is not fully approved by the Committee on the Safety of Medicines. Intracavernosal injections of prostaglandin or papaverine (by itself or with phentolamine) reliably produce erections, but are less acceptable to some couples as a means of allowing intercourse. If the cavernosal blood supply is shown to be inadequate (by arteriograms), surgery may be attempted to increase the arterial input.

In **premature ejaculation** it is possible to achieve some delay by utilizing a side effect of the SSRI drugs or clomipramine. However, the effect is not predictable and is often quite small. Vibrators are used, with variable success, in **female anorgasmia** and in **delayed ejaculation** in males. Hormone replacement in postmenopausal women can reverse **atrophic vaginitis,** a frequent cause of pain and bleeding on intercourse. Hormone replacement in men is not as widely accepted, and should be reserved for cases with demonstrated androgen deficiency.

Sexual deviations and gender dysphoria

If the deviation is harmful, it is usual for the police and the courts to be involved before psychiatrists. However, some patients come to psychiatrists first, and then ethical dilemmas can arise over disclosure. The general rule is that if criminal activity is taking place, especially if it involves a child, the doctor is bound to break the usual rules of confidentiality and inform the social services and/or police of what has been disclosed.

Management of any deviation is much easier and treatment is more likely to be successful if the patient is either self-referred or comes with clear motivation to reduce the deviant behaviour. Those who are referred by courts or come as a result of pressure from family members or advisers are much less likely to do well.

Treatment is by behavioural, cognitive, or dynamic psychotherapy, by couple or family therapy, or by medication in specialist centres. In cases where the patient wishes to be free of all sexual urges, the use of antilibidinal medication can be considered. Cyproterone acetate is the most satisfactory, but ethinyloestradiol and medroxyprogesterone can be used as alternatives. Ethical questions may be raised, especially in younger patients.

Management of transsexualism

It is important not to move too quickly into gender reassignment procedures, and it is usual to recommend that the patient should live as a member of the opposite sex for a period of 2 years, usually with the aid of hormone therapy, before any consideration of surgery. It is then possible to carry out gender reassignment operations with hormone therapy in selected cases, but a great deal of counselling is necessary after surgery and adjustment is variable.

Learning difficulties

Learning disability is not a disease; it does not respond to medical treatment. The appropriate treatment is that for the underlying mental condition (if any). Drugs do not control primary behavioural disturbances, and they may make behaviours much worse.

- Always carry out a physical examination. Refer for medical or surgical advice if pain is apparent. General diagnostic screening should be undertaken if there are signs of physical ill health.
- Offer treatment appropriate to the underlying mental condition (if any). Sedation may be necessary to control the violently disturbed patient. Caution is necessary in view of frequent coexistence of epilepsy; lorazepam is probably the safest sedative (2 mg orally, intraveously, or intramuscularly).
- Do *not* initiate regular antiopsychotic medication unless there are psychotic symptoms. Their use should only be started by a specialist who has considered all other options.

Screening for specific syndromes of learning disability is generally pointless. Specialist investigations are best left to the specialist services. Long-term care in hospital is not an option.

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Chapter 11

Things you need to know about

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Mental Health Act 1983

A working knowledge of the Mental Health Act (MHA) is essential for all psychiatrists. This section summarizes some of the things you will need most frequently. More details are to be found in the Code of Practice 1999.

The Code of Practice begins with a statement of guiding principles which, although not included in the Act itself, should be respected. These principles are that people subject to the Act should:

- receive recognition of their human rights under the European Convention on Human Rights (ECHR)
- have diversity of age, gender, religion, ethnicity, sexual orientation, and culture respected
- have their needs taken fully into account
- receive treatment or care in the least controlled and segregated facilities compatible with health and safety
- be treated in such a way as to promote self-determination and personal responsibility, as far as is practicable
- be discharged from detention (or other restrictions) as soon as it is clear that they are no longer justified.

Definitions (Section 1)

Mental disorder is defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'.

Four categories of mental disorder are specified as follows:

1. **Mental illness:** not defined.
2. **Severe mental impairment:** 'a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'.
3. **Mental impairment:** defined in the same way as severe mental impairment except that the phrase 'severe impairment' is replaced by 'significant impairment'.
4. **Psychopathic disorder:** 'a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'.

NB Acute intoxication, substance dependence, or sexual preference disorders alone do not qualify for these criteria.

Assessment prior to admission to hospital

As well as satisfying the criteria for mental disorder, a patient may be compulsorily admitted under the MHA in the interests of his/her own health, **or** safety, **or** for the protection of others.

The following criteria should be considered.

- The guiding principles in the Code of Practice
- The patient's wishes and views
- Social and family circumstances
- Nature of illness/behaviour disorder and its course

- What may be known about the patient by the nearest relative or others; assessing the reliability of this information
- Other forms of care or treatment possible including, where relevant, whether the patient would accept informal or outpatient treatment
- Needs of the family or others with whom s/he lives and the burden on them of a decision not to admit
- Need for others to be protected from the patient, considering the reliability of evidence of risk to others, its nature and degree, the willingness and ability of those with whom the patient lives to cope with the risk, and whether there are alternative options for managing the risk
- The interests of the patient's own health, considering the known
- history of the disorder, the views of the patient, relatives, or close friends about the likely course, and the impact that the future course of the illness may have on relatives or others with whom the patient lives

If the patient is subject to the effects of sedative medication or the short-term effects of drugs or alcohol, the **approved social worker** (ASW) should wait to apply for compulsory admission until the effects have abated unless this is not possible because of the patient's disturbed behaviour. The ASW is responsible for coordinating the process of assessment and implementing decision for application, and for conveying the patient to hospital.

The **doctor** is responsible for the following.

1. Carrying out a direct personal examination of the patient's mental state, and obtaining and considering all available relevant medical information.
2. Deciding if the patient is suffering from mental disorder within the meaning of the MHA, its seriousness, and the need for further assessment and/or treatment in hospital.
3. Considering the criteria given above and discussing them with the applicant and the other doctor involved.
4. Specifically addressing the legal criteria for admission and, if they are met, providing a recommendation setting out the basis for this conclusion.
5. Ensuring that a hospital bed is available if needed.

Wherever possible, the doctors and ASWs should consult colleagues (e.g. community psychiatric nurses (CPNs)), but they retain final responsibility.

Section 2 pointers

Section 2 should be preferred to Section 3 where:

(a) The diagnosis and prognosis of a patient's condition are unclear.
(b) There is a need to carry out an inpatient assessment in order to formulate a treatment plan.
(c) A judgement is needed as to whether the patient will accept treatment on a voluntary basis following admission.
(d) A judgement has to be made as to whether a particular treatment proposal, which can only be administered to the patient under Part IV of the MHA, is likely to be effective.

(e) A patient who has already been assessed, and who has been previously admitted compulsorily under the MHA, is judged to have changed since the previous admission and needs further assessment.
(f) The patient has not previously been admitted to hospital either compulsorily or informally and has not been seen regularly by community services.

Section 3 pointers

Section 3 should be preferred where:
(a) A patient has been admitted in the past, is considered to need compulsory admission for the treatment of a mental disorder which is already known to his/her clinical team, and has been assessed in the recent past by that team.
(b) A patient already admitted under Section 2 and who is assessed as needing further medical treatment for mental disorder under the MHA at the conclusion of his/her detention under Section 2 is unwilling to remain in hospital informally and to consent to the medical treatment.
(c) A patient is detained under Section 2 and assessment points to a need for treatment under the MHA for a period beyond the 28 day detention under Section 2. In such circumstances an application for detention under Section 3 should be made at the earliest opportunity and should not be delayed until the end of Section 2 detention. Changing a patient's detention status from Section 2 to Section 3 will not deprive him/her of a Mental Health Review Tribunal (MHRT) hearing if the change takes place after a valid application has been made to the Tribunal but before it has been heard. The patient's rights to apply for a Tribunal under Section 66(1)(b) in the first period of detention after his/her change of status are unaffected.

Capacity and consent to treatment

Common law applies to all patients, detained or informal. Therefore valid consent is required from a patient before medical treatment can be given except where the law provides authority to treat him/her without consent.

It is the personal responsibility of any doctor proposing to treat a patient to determine whether the patient has the capacity to give a valid consent. In order to have capacity an individual must be able to understand:

- the nature of the proposed treatment
- why someone has said that s/he needs it
- the treatment's principal benefits and risks
- the consequences of not receiving the proposed treatment.

It will be necessary to ensure that any avoidable barriers to comprehension, such as language difficulties or deafness, are alleviated as far as possible before making an assessment, and that information is provided in an appropriately simple and comprehensible form. It is also necessary for the patient to retain the information needed to make the assessment. If memory is impaired, reasonable efforts should be made to provide the

information needed and to elicit the patient's view of it before concluding that capacity is lacking.

A person suffering from a mental disorder is not necessarily incapable of giving consent. The legal propositions regarding this are summarized in Lord Donaldson's judgement in *Re. T. (Adult: Refusal of Medical Treatment)* (1992) All E.R. 649, 664 C.A. This presumes a capacity of an adult to refuse treatment if the reasons are 'rational or irrational, unknown or even non-existent'. An adult may be deprived of this capacity by long-term mental incapacity, retarded development, or 'by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs'.

Junior doctors may be faced with the question of capacity in two common situations:

- a disturbed patient on a general ward who is refusing treatment
- a patient suffering from a mental disorder which is leading to behaviour that is an immediate serious danger to him/herself or to other people.

In the first case, the MHA should not be applied unless the treatment being refused is specifically intended to treat a mental disorder. If treatments for other medical problems are being refused, an assessment of capacity must be made, and if it is lacking, the patient can be treated without consent in his/her best interests (reasonable efforts having been made to ascertain what the patient's view of these would be if capacity were present). There is no necessity for a psychiatrist to be involved in assessment or treatment under these circumstances, although they may be well placed to advise medical colleagues.

In the second case, the MHA guidelines state that 'on rare occasions involving emergencies, where it is not possible immediately to apply the provisions of the MHA … a patient … may be given such treatment as represents the minimum necessary response to avert that danger'.

In both cases decisions can be complex and it is appropriate to seek advice from senior colleagues.

A less common situation is that of the patient with long-term incapacity who is unable to consent to treatment but does not resist it. While it is legal to treat such patients without using compulsory powers, the case of *R* v *Bournewood Community Mental Health Trust* (1998) drew attention to the problem that the rights of informal patients without capacity are not adequately protected. Consideration should be given to detaining such patients so that a Tribunal can review treatment decisions.

Consent to treatment (Part IV of the Mental Health Act)

This applies to:

- treatments for mental disorder
- all formal patients except those who are detained under Sections 4, 5, 35, 135, and 136, subject to guardianship or conditionally discharged; these patients have the right to refuse treatment as have informal patients, except in emergencies.

Part IV states that:

(i) any treatment can be given without the patient's consent unless the MHA or Department of Health and Social Services (DHSS) regulations specify otherwise.

(ii) under Section 57, psychosurgery and treatments specified in DHSS regulations as giving rise to special concern can only be given if
   (a) the patient consents, and
   (b) a multidisciplinary panel appointed by the Mental Health Act Commission confirms that his consent is valid, and
   (c) the doctor on the multidisciplinary panel certifies that the treatment should be given; before doing so s/he must consult two people, one a nurse and the other neither a nurse nor a doctor, who have been concerned with the patient's treatment.

NB As the treatments specified in Section 57 give rise to particular concern, this section applies to all formal and informal patients.

(iii) under Section 58, certain treatments can only be given if
   (a) patient consents, or
   (b) an independent doctor appointed by the Mental Health Act Commission confirms that treatment should be given; before doing so s/he must consult two people, one a nurse and the other neither a nurse nor a doctor, who have been concerned with the patient's treatment.

Section 58 applies to treatments named in DHSS regulations (including ECT). Medication can be given without the patient's consent for 3 months; after that it is subject to the safeguards laid down in Section 58.

NB Under Section 62, any treatment for mental disorder can be given without consent in specific emergencies, subject to restrictions when a treatment is irreversible or hazardous.

A summary of assessment for admission under the MHA is given in Table 11.1.

Table 11.1 Assessments for admission under the Mental Health Act 1983

Section	Duration	Application	Procedures	Discharge
2. Admission for assessment	28 days maximum	ASW or nearest relative Applicant must have seen patient within previous 14 days	Two doctors must confirm that: (a) Patient is suffering from mental disorder of a nature or degree which warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period, and (b) s/he ought to be detained in the interests of his/her own health or safety or with a view to the protection of others.	By any of the following: (a) RMO (b) Hospital managers (c) Nearest relative who must give 72 hours notice; RMO can prevent nearest relative discharging patient by making a report to hospital managers (d) MHRT: patient can apply to a tribunal within the first 14 days of detention
4. Admission for assessment in cases of emergency	72 hours maximum	ASW or nearest relative Applicant must have seen patient within previous 24 hours	One doctor must confirm that: (a) It is of 'urgent necessity' for the patient to be admitted and detained under Section 2, and (b) Waiting for a second doctor to confirm the need for an admission under Section 2 would cause 'undesirable delay'	

Table 11.1 Contd.

Section	Duration	Application	Procedures	Discharge
3 Admission for treatment	6 months, renewable for a further	By ASW or nearest relative or in cases where nearest relative	Two doctors must confirm that: (a) patient is suffering from one of the four specified categories of mental disorder,	By any of the following: (a) RMO (b) Hospital managers
	6 months, then for 1 year at a time	consent or is displaced by County Court, or it is not 'reasonably practicable' to consult him/her	a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital, and (b) if patient is suffering from psychopathic disorder or mental impairment, such treatment is likely to 'alleviate or prevent a deterioration' of his/her condition, and (c) it is necessary for his/her own health or safety or for the protection of others that s/he receives such treatment and it cannot be provided unless s/he is detained under this section	(c) Nearest relative who must give 72 hours notice; RMO can prevent nearest relative discharging patient by making a report to hospital managers (d) MHRT: patient can apply to a tribunal within 6 months of admission and during each subsequent renewal period

Renewal: Under Section 20, RMO can renew a Section 3 detention order if original criteria still apply and treatment is likely to 'alleviate or prevent a deterioration' of patient's condition. In cases where patient is suffering from mental illness or severe mental impairment but treatment is not likely to alleviate or prevent a deterioration of his condition, detention may still be renewed if he is unlikely to be able to care for himself, to obtain the care he needs, or to guard himself again serious exploitation.

5(2)	72 hours maximum	Doctor of informal inpatient treatment or nominated deputy (usually on-call doctor)	Reports to hospital managers that application for compulsory admission 'ought to be made'. Applies to inpatients being treated for physical disorders but not those seen in A & E. Where possible, the nominated deputy should contact the nominated doctor or another consultant before using Section 5(2)	Should be converted to Section 2 or 3, or rescinded as soon as possible

136. If it appears to a police officer that a person in a public place is 'suffering from mental disorder' and is 'in immediate need of care or control', s/he can take that person to a 'place of safety', usually a hospital. Section 136 lasts for a maximum of 72 hours so that person can be examined by a doctor and interviewed by an ASW and 'any necessary arrangements' made for his/her treatment or care

135. If there is reasonable cause to suspect that a person is suffering from mental disorder and (a) is being ill-treated or neglected or not kept under proper control, or (b) is unable to care for him/herself and lives alone, magistrates can issue a warrant authorizing a police officer (with a doctor and ASW) to enter any premises where the person is believed to be and remove him/her to a place of safety

ASW, approved social worker; RMO, ; MHRT, Mental Heath Review Tribunal; A& E, accident and emergency.

Patients involved in criminal proceedings (Part III of the Mental Health Act)

Hospital order (Section 37)

The **duration** is initially for 6 months and is renewable for a further 6 months, and then yearly.

The **procedure** is as follows. The order can be made by a Crown or Magistrates' Court in the case of a convicted offender in place of a prison sentence (offences include manslaughter but not murder). The Magistrates' Court need not record a conviction if satisfied that the offender was suffering from mental illness or severe mental impairment at the time of the offence. A hospital order requires evidence from two doctors that:

- the offender is suffering from one of the specified categories of mental disorder of a nature and degree which makes detention for medical treatment appropriate, and
- if suffering from psychopathic disorder or mental impairment, such treatment is likely to 'alleviate or prevent a deterioration' of his/her condition, and
- taking into account all the relevant circumstances a hospital order is most appropriate.

Discharge is by the responsible medical officer (RMO), hospital managers, or MHRT (one application is allowed between 6 and 12 months and then yearly. The case is automatically reconsidered by MHRT 3 years after the last tribunal referral).

Restriction order (Section 41)

The **duration** may be specified by court or without limit.

The **procedure** is as follows. The order can be made by a Crown Court only after imposition of a hospital order if:

- this is necessary to protect the public from 'serious harm',and
- at least one of the doctors who made recommendations for the hospital order gave his/her evidence orally.
- **Discharge** is by either the Home Secretary or MHRT (rules as for Section 37).

Reference

Mental Health Act 1983. Code of Practice. London: Stationery Office, 1999.

Police and Criminal Evidence Act 1984

The Police and Criminal Evidence Act 1984 was designed to regulate police conduct and the admissibility of evidence in court. Sections 53-65 deal with the treatment and questioning of people in police custody.

If a detained person appears mentally disordered (defined according to MHA criteria), police must ask an 'appropriate adult' to come to the police station. Concern is that mentally disordered will give evidence which is unreliable and/or self-incriminatory. Similar provision is made for juveniles. This does not apply in emergencies (e.g. where risk to others can be reduced by questioning someone immediately).

The 'appropriate adult' can be a relative, a carer, or someone who has worked with the mentally disordered, but it cannot be the person's solicitor. The adult cannot be employed by the police. The Code of Practice states that a well-informed professional may be preferable to an ill-informed relative, but also that the person's choice of adult is to be respected.

The 'appropriate adult' should be present during searches and questioning, observe fairness of interviews, advise the person being questioned, and facilitate communication. The person being questioned is entitled to consult privately with the appropriate adult at any time (this is often not respected).

The Act also makes provision that mentally disordered detainees should not be subject to voluntary searches (because of doubts about the quality of their consent). In all cases the more stringent procedures which cover involuntary searches must be applied. If confessions made by mentally disordered people are used in evidence against them in court, the judge must refer to the unreliability of such confessions in his/her summing up.

Children and Young Person's Act 1969

Emergency Protection Order (for children)

Sometimes a psychiatric assessment of a child will reveal a dangerous and harmful situation so that emergency care is needed. If so, the duty social worker as well as the consultant in charge of the case should be contacted urgently.

The Emergency Protection Order replaced the old Place of Safety Order under the Children and Young Person's Act 1969. It was felt following the Cleveland Inquiry that the place of safety order was used rather too indiscriminately, and that parental rights were too easily infringed.

An application for an Emergency Protection Order can be made under Section 44 of the Children Act 1989. The court will make an order if there are reasonable grounds to believe that the child is likely to suffer significant harm, or cannot be seen in circumstances where s/he might be suffering significant harm. The court will wish to know why a child should be removed as a matter of urgency, and why parental cooperation should be dispensed with at this stage.

The duration is limited to 8 days, with a possible extension for a further 7 days. Applications to lift the order can be made between 72 hours and 8 days after it has been made.

The person obtaining the order has limited parental responsibility. The court will decide about parental contact, and medical and psychiatric assessment.

Reform of the Mental Health Act 1983

Proposals to amend the MHA have been made repeatedly since 1987, principally to increase powers to compel patients who do not meet the criteria for compulsory admission, but are believed by clinicians to be at risk of future relapse, to take medication while outside hospital. Although early proposals were rejected by the government, increased concern about the perceived risks of the move to community care led to the amendment of the MHA in 1995 with the introduction of Section 25 (Supervised Discharge). While this can be used to require patients to accept a community care plan, neither Section 25 nor Section 7 (Guardianship) can be used to force medication on patients not meeting admission criteria. Both Section 25 and Section 7 have been regarded as of value for a small number of patients who cooperate with the requirements placed on them, but of little value for patients who actively reject the proposed care plan.

In 1998 a review of the MHA recommended a radically changed Act based on the central principle that the decision to give compulsory treatment should be based on the lack of capacity to refuse it. This was rejected by government, which retained the current principles in a Draft Bill in 2002 but proposed that a new Act should have greatly increased powers to compel patients in the community to take medication. The proposed criteria for deciding who could be forced to take treatment were also broadened to include those with 'untreatable' personality disorders and substance dependency. This Draft Bill was opposed by a 'Mental Health Alliance', which united all the major professional and service user groups, who regarded the Bill as shifting the role of mental health services away from treatment and towards authoritarian control. The government responded with a revised Draft Mental Health Bill, published in September 2004. The main differences between this proposal and the MHA 1983 are as follows.

- It will be possible to require patients to accept care plans, including medication, outside hospital (although medication will only be given forcibly in clinical settings). Guardianship and Supervised Discharge will be abolished.
- The current distinction between assessment (Section 2) and treatment (Section 3) will be replaced with a single form of compulsory care plan, which could include hospital or community assessment or treatment as appropriate.
- All use of compulsory powers will be reviewed by a tribunal or court after 28 days, without requiring the patient to appeal.
- Services will be required to produce a care plan within 5 days of applying compulsory powers.
- The currently defined role of 'nearest relative' will be replaced, and patients will be able to nominate their own choice of relative and to have access to independent advocacy.
- Carers will have statutory rights to be consulted.
- Current roles such as ASW will be replaced with roles based on competence rather than professional background.

This Draft Bill was again strongly criticized by the Mental Health Alliance, which continued to regard the changes as likely to greatly expand the use of compulsion and to infringe patient's rights, without commensurate benefit to patients or the public. The Draft Bill was then subject to pre-legislative scrutiny by a parliamentary committee. This was also highly critical of the proposals, reiterating many of the concerns expressed by professionals and service users, and making a total of 107 recommendations for changes. In July 2005 the government responded by accepting a number of these criticisms, most importantly the following.

- Guiding principles should be included in the Bill.
- As in the MHA 1983, compulsory treatment should not be given to people with a sole diagnosis of dependency on drugs and alcohol.
- Patient's rights should be strengthened in a number of ways, including giving greater weight to advance decisions and statements. (These are statements made when well about preferred treatment options in the event of future illness. The MHA 1983 does not require that these are taken into account when making treatment decisions concerning detained patients).

Although these changes have not been sufficient to satisfy its opponents, at the time of writing the government intends to bring a further Bill before parliament and to implement a new Act by April 2007.

Advance statements, decisions, and directives

An advance statement is a declaration made by a service user about preferences for treatment should future episodes of psychosis impair his/her capacity to make his/her own decisions. The statement is intended to influence professionals towards practice which is more acceptable to the service user. It provides a way in which clinicians can be helped to determine what is in a service users 'best interests'. However, the criteria used in the MHA 1983 to determine treatment do not specifically require that the clinician consider the client's 'best interests' in its legal sense. Therefore the preferences expressed in the advance statement can be ignored or overridden by the treating clinician. A study in Bradford sought to encourage service users to develop advance statements, but the principal finding was that only a very small proportion of service users made statements and the project generally 'failed to enthuse them'. It was suggested that, while intended to empower service users, the advance statements were not in fact perceived as doing so. This leaves open the question of whether, if clinicians were bound by such statements or were required to take them into account, they might be perceived as empowering by service users and be more widely taken up.

The Joint Committee of Parliament which scrutinized the Draft Mental Health Bill 2004 recommended that the government should legislate to make it possible for people to 'make advance statements and record advance decisions, particularly if there is a treatment they would prefer

not to receive … these statements [should be] taken into account by, but not become binding on, clinicians …'. The government's response agreed that 'advance directives and advance statements are an important way for patients to exercise some dignity and control over their treatment' and patients should have the opportunity to record in advance their refusal of certain treatments as well as their preferences, although this would not be binding on clinicians (http://www.dh.gov.uk/assetRoot/04/11/52/68/4115268.pdf).

The terms 'advance decision', 'advance statement', and 'advance directive' appear to be used interchangeably in these discussions of proposed UK legislation, although they may have specific meanings in other jurisdictions.

Joint crisis plans

These are also a form of advance statement, but differ from the above in two crucial aspects. First, they are formulated together with the care team (hence 'joint' plans), and resolution of any conflicts between service user preferences and the care team are sought when drawing up the plan rather than being left to cause difficulties when a crisis arises. Secondly, a neutral facilitator works with the service user and care team to draw up the plan. Therefore the resource requirements, both in terms of time and for the facilitator, are greater than simply asking the service user to prepare a statement. A randomized controlled trial in the UK (Henderson *et al.* 2004) has reported that joint crisis plans can reduce the use of detention under the MHA. Ten of the 80 service users who had joint crisis plans (13 per cent) were detained over a 15-month follow-up, compared with 21 out of 80 (27 per cent) in the control group (significant at the level of $P = 0.03$). Admissions were slightly reduced but not to a statistically significant extent; the risk of admission in the intervention group was 0.69 of that in the control group ($P = 0.07$) and the mean number of bed days was only reduced from 36 to 32 ($P = 0.15$).

However, only 36 per cent of service users who could have taken part actually agreed to do so; therefore, as with the Bradford study, there are clearly obstacles to take up. The authors suggest that these include the belief that joint crisis plans would not make any difference, reluctance to consider the possibility of becoming ill again, and that existing plans were felt to be adequate.

Crisis cards

These were developed by the user movement 20 years ago as an early version of advance statements. They are designed to be carried by service users to provide immediate information on preferences in crisis situations. A crisis card was used in a pilot study in Croydon which preceded the trial of joint crisis plans (Sutherby *et al.* 1999), and this and various other versions have been adopted by some local services. They differ from joint crisis plans in that there is no specific process by which differences between the service users' and professional views of treatment in crisis are identified and resolved.

Crisis plans

The term 'crisis plan' is commonly in use in services; it is a list of actions to be taken in a future crisis which may form part of care programme approach (CPA) documentation. These tend to be drawn up by clinicians, possibly with no service user involvement. However, if carried out as part of a CPA review at which the service user's preferences for future treatment in crisis are recorded, they would have the characteristics of an advance statement.

Further reading

Henderson, C., Flood, C., Leese, M., *et al.* (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trial. *British Medical Journal*, **329**, 136.

Sutherby, K., Szmukler, G., Halpern, A., *et al.* (1999). A study of crisis cards in a community psychiatric service. *Acta Psychiatrica Scandinavica*, **100**, 56–61.

The care programme approach

The CPA was introduced in 1991 to provide a framework for effective mental health care. It aims to guide good clinical practice and to prevent patients from 'slipping through the net'. The key principles are applicable to all service users, even those who require only an intervention by a single discipline.

Its four main elements are as follows.

1. **Assessment of health and social care needs** The systematic assessment begins with a good psychiatric history. Most patients with severe mental illness will have a wide range of needs, and a full assessment will involve information obtained from informants: family, friends, and professional and non-professional carers. It is now mandatory that assessment of mental health needs be integrated with that of social needs in a single care coordination approach. A joint assessment process prevents duplication for the user and carer, and ensures that the services allocated from whatever source match need.
2. **A written care plan** For patients requiring multidisciplinary input, a care plan should be agreed at a ward round or CPA meeting with everyone who will be involved in implementing it. The plan should be agreed as far as possible with the patient and with carers. For other patients, this might simply involve a plan for outpatient treatment being written in the notes following assessment, although even this should be discussed and agreed with the patient.
3. **Care coordinator** The care coordinator has responsibility for the coordination of the care programme. S/he is responsible for keeping in close contact with the patient, and for advising the other members of the care team of changes in the circumstances of the patient which might require review or modification of the care plan. The care coordinator should be the professional with the closest relationship with the patient; this will often be a CPN or social worker, but could be a psychiatrist in training.
4. **Ongoing reviews** Review and evaluation of care planning should be regarded as an ongoing process. There is no required set period for

review, but at each review meeting the date of the next review must be set and recorded. Any member of the care team or the patient or carer must be able to ask for a review at any time. If the team decide that a review is not necessary, the reasons for this must be recorded. Trusts should ensure that a system is in place to collect data on all service users whose care is managed through the CPA.

Who should receive the CPA?

In order to establish consistency of practice, from April 2001 services are required to deliver the CPA according to two levels: standard or enhanced. The characteristics of people receiving either form are listed below.

Standard CPA

- They require the support or intervention of one agency or discipline or low-key support from more than one agency or discipline.
- They are more able to manage their mental health problems.
- They have an informal support network.
- They pose little danger to themselves or others.
- They are more likely to maintain appropriate contact with services.

Enhanced CPA

- They have multiple care needs, including housing, employment, etc., requiring inter-agency coordination.
- They are only willing to cooperate with one professional or agency, but they have multiple care needs.
- They may be in contact with a number of agencies.
- They are likely to require more frequent and intensive interventions.
- They are more likely to have mental health problems coexisting with other problems such as substance misuse.
- They are more likely to be at risk of harming themselves or others.
- They are more likely to disengage with services.

Needs assessment

The assessment of need by both social and health services is a requirement of the CPA. Under the NHS and Community Care Act 1990, social services are also required to provide an assessment of social care needs to all those who require one, including those with mental disorder, and these types of assessment should overlap as much as is practicable.

Table 11.2 Areas of need in severe mental illness

Accommodation	Alcohol
Food	Drugs
Household skills	Company of others
Self-care	Intimate relationships
Occupation	Sexual expression
Physical health	Child care
Psychotic symptoms	Basic education
Information about condition and treatment	Telephone
Psychological distress	Transport
Safety to self	Money
Safety to others	Welfare benefits

Defining needs

Needs can be defined on a population or individual basis, and from the perspectives of politicians, clinicians, carers, and patients; clearly these will differ. A working definition of need in the sense in which it is used in the CPA is that a need exists where the patient 'is able in some way to benefit from care', where this care is medical or social. The needs are not limited to the care which happens to be available; a broader definition of need may suggest services which could be developed.

Needs in severe mental illness

The needs for care of the severely mentally ill are often considerable, and involve physical, mental, and social needs. While a good psychiatric history and examination should identify many of these, some, particularly social care needs, may be insufficiently covered. A standardized instrument, the Camberwell Assessment of Needs (CAN) identifies 22 areas of need to be explored in a full assessment (Table 11.2). The instrument enables problems in these areas to be rated from interviews with the patient, or by the keyworker, in about half an hour, and distinguishes unmet needs from those already met by help from informal carers or statutory services.

Copies of the Camberwell Assessment of Need are obtainable from the Health Services Research Department, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF (Tel: 0171-919-2610; Fax. 0171-277-1462).

Community visits

In this section we discuss some practical aspects of patient contact by psychiatrists in non-medical settings. Community visiting is highly informative, enjoyable, and appreciated by patients and carers. Visiting people at home provides an invaluable insight into the social context of the patient's psychopathology and his/her level of functioning. The techniques of assessment and management described in this book are equally applicable outside the hospital (e.g. in the patient's home, a hostel or day centre, a police station, or even the street). However, these settings are less predictable than the clinic or ward and more emotionally demanding. As a consequence some special considerations apply.

Patients may be seen in the community as part of the assessment process, for planned treatment or review, as an emergency intervention in a crisis, or in a formal MHA assessment. Family assessment and intervention may very usefully be carried out in the home. CPA reviews may be held in non-medical settings. With the possible exception of the traditional consultant domiciliary consultation requested by the GP, all home visiting should be part of the work of the multidisciplinary community mental health team. Home assessments by psychiatrists should generally be carried out with colleagues in the team. Home treatment and review will be part of a previously agreed care plan. Emergency assessments should be carried out in accordance with locally agreed operational policies or protocols. 'Good practice' in the conduct of an MHA assessment is set out in the MHA Code of Practice 1999, with which, for medico-legal reasons, all psychiatrists is England and Wales should be familiar.

Planning the visit

The reasons for and expected outcome of any community visit should be identified. If hospital admission is the expected outcome of an emergency assessment, the availability of a bed should be confirmed before setting out. Alternatively, the possibilities of intensive community support to an acutely ill patient should be explored prior to the visit. If the patient is likely to require medication, is a prescription available? A mobile telephone can be used to make arrangements, and to contact the patient if you get lost or delayed or have difficulty in gaining access. The visiting psychiatrist should have the maximum possible information. Prior to carrying out an emergency or new patient assessment informants should be contacted by telephone. Any documentation should be sought and read. It is helpful to know the exact nature of the community concerns before any doorstep assessment.

- What is the alleged psychopathology?
- What abnormal behaviours have others reported?
- What are the patient's documented risks to self or others?

The patient should be generally be given notice of the visit, which should preferably take place at a mutually agreed time. The reason for and conduct of any unannounced visit should be very clearly thought out in advance. The journey to a visit should be planned: find out exactly where to go, how long it will take, and where to park. At night take a

torch. If a colleague, carer, or the police are to attend the visit, a rendezvous should be agreed. Arrangements for access to the home should be identified before the visit: if access is impossible, consideration should be given to the use of Section 135 of the MHA. This requires the involvement of an ASW colleague.

Safety

The possible risks of any community visit should always be considered.

- Is the patient (and family) known to services?
- Is there any past history of violence or aggression?
- Is the area safe to visit?

If there are any concerns about safety the psychiatrist should visit with a colleague from the team, the GP, or a person previously known to the patient. Unobtrusive police presence may be advisable during an MHA assessment and is increasingly required in some areas by ambulance crews. As a general principle, *another team member should know about any community visit.* Community staff have been held hostage! If staff feel unsafe during a visit, they should not hesitate to retreat. If, following a strategic retreat, there are concerns about the safety of other household members, some plan of action should be drawn up, for example a follow-up telephone call or contact with the police.

Carrying out a visit

Any home visit should be carried out in a calm and confident manner. The psychiatrist is often expected to take the lead in the conduct of the visit, and therefore should be clear about its aim. Communications should be clear and unambiguous. Certain courtesies should be observed, for example seeking permission to enter the house and establishing with the patient and any carer the purpose of the interview, its likely duration, and where it should be carried out. Introductions should be made. The composition of the household should be established; visitors should be sensitive to the needs of children in the home. When carers are present, they should be allowed to contribute to the discussion of the patient's problems, although rights to confidentiality should always be considered. It may be appropriate to interview the patient and carers separately. It is quite reasonable to ask the patient to turn off the television or remove his/her pet from the interview setting. If one aim of the visit is to assess the patient's level of functioning and home environment, this should be carried out sensitively, although it is usually appropriate to share any concerns about welfare with the patient. At the end of the visit a plan of further care should be negotiated with the patient and carer. Preferably, the timing of any further home visit or outpatient contact should be agreed. Details of a contact person, address, and telephone number should be offered to the patient and carer. The referrer should be contacted following an assessment, which should be recorded in the case notes. It will often be helpful to carry out a short debriefing session with any accompanying colleague immediately after the visit, both to clarify the outcome of the visit and for emotional support.

Emergency and Mental Health Act assessments

The conduct of emergency assessments will reflect the treatment paradigms, resource base, and policies of the local service. There may be a crisis intervention team capable of responding to requests from GPs, patients and carers, and community agencies for the assessment and treatment of people in psychosocial crisis. A service may be able to provide 24-hour home care for acutely psychotic patients as an alternative to inpatient admission, or may only be able to offer institution of treatment, intermittent home visits, and outpatient attendance. The general principles are set out above: careful planning (the more important the more acute the situation), consideration of personal safety, calm conduct throughout the intervention, and appropriate follow-up. Access arrangements are crucial to effective emergency interventions.

Assessments for admission under the MHA should generally follow the 'good practice' guidelines set out in the Code of Practice, or its equivalent in other jurisdictions. The Code of Practice not only amplifies the criteria for compulsory admission set out in the MHA but also provides details about the appropriate conduct of the assessment. MHA assessments are often unnecessarily chaotic and distressing for patients, carers, and the staff involved. Although a rapid response to a perceived crisis is often demanded, careful planning is always appropriate. The ASW has 'overall responsibility for coordinating the process of assessment and, where he decides to make an application, for implementing the decision' (Code of Practice 2.11). The psychiatrist (always approved under Section 12 of the MHA) may wish to review these plans before the assessment and should usually have made arrangements for the patient's admission to an appropriately staffed ward in anticipation of a decision to admit either under the MHA or informally. An ambulance and, if necessary, the police should be in attendance. Assessment should be carried out jointly by the recommending doctors and the ASW unless there are good reasons for undertaking assessments separately (Code of Practice 2.3). The role of the ASW is spelt out in detail (Code of Practice 2.11–2.16). The medical examination requires 'direct personal examination of the patient's mental state' and 'consideration of all available relevant medical information'(Code of Practice 2.23). Examining doctors should always discuss the patient with each other (Code of Practice 2.25).

Although the majority of compulsory admissions require prompt action to be taken, the ASW has up to 14 days from first seeing the patient to make an application. Any decision not to make an application should be accompanied by plans to implement appropriate alternative arrangements. The ASW also has a duty to inform the nearest relative of the reasons for not making an application and his/her right to apply (Code of Practice 2.27).

Home visits to elderly patients

If the patient is being assessed at home, some inspection of the home circumstances should be made. This is an important part of evaluating the degree of risk posed to the patient (and possibly others). Remember that self-neglect is not diagnostic of any particular disorder and can occur in severe functional illness as well as dementia.

- Is the dwelling in a good state of repair and decoration?
- Is it secure?
- Are gas, electricity, and water connected?
- Is there adequate heating and lighting?
- Is the gas ever left on unlit?
- If the patient smokes, is there evidence of the careless use of lit cigarettes?
- Is the patient able to call for help if necessary (e.g. via a centralized alarm system)?
- Is there enough food in the home to make, at least, small snacks/hot drinks?
- Is there evidence of urinary or faecal incontinence?
- Are any pets well cared for?

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Appendix 1

The AUDIT questionnaire

Circle the number that comes closest to the patient's answer.

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2–4 times a month
(3) 2–3 times a week
(4) 4 or more times a week

2.[a] How many drinks containing alcohol do you have on a typical day when you are drinking? (Code number of standard drinks)

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7 or 8
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the past year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the past year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the past year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

[a] In determining the response categories, it has been assumed that one 'drink' contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25% from 10 g, the response category should be modified accordingly.

9. Have you or someone else been injured as a result of your drinking?

(0) No
(1) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) No
(1) Yes, but not in the last year
(4) Yes, during the last year

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Mini-mental state examination

Orientation		Score	points
1. What is the	Year?		… 1
	Season?		… 1
	Date?		… 1
	Day?		… 1
	Month?		… 1
2. Where are we?	Country?		… 1
	County?		… 1
	Town?		… 1
	Hospital?		… 1
	Floor?		… 1

Registration

3. Name three objects, one per second (e.g. BALL, FLAG, TREE).
   Then ask the patient all three after you have said them.
   Give one point for each correct answer.
   Repeat the words until patient learns all three … 3

Attention and concentration

4. Spell 'world' backwards: D L R O W … 5

Recall

5. Ask for the names of the three objects learned in Q3.
   Given one point for each correct answer. … 3

Language

6. Point to a pencil and a watch.
   Ask the patient to name them as you point … 2
7. Ask the patient to repeat 'No ifs, ands, or buts' … 1
8. Ask the patient to read and obey the following:
   CLOSE YOUR EYES … 1
9. Ask the patient to carry out a three-stage command:
   'Take the paper in your right hand, fold it in half, and put it on the floor.' … 3
10. Ask the patient to write a sentence of their own.
    (The sentence should contain a subject and an object and should make sense. Ignore spelling errors in scoring.) … 1
11. Ask the patient to copy a design (two overlapping pentagons). Give one point if all sides and angles are preserved and the intersecting sides form a quadrangle. … 1

Total **… 30**

After Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975) 'Mini-mental state'. A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* **12**, 189.

Abbreviated mental test scoring

Hodkinson M (1972) Evaluation of a mental test score for assessment of mental impairment in the elderly *Age and Ageing* **1** 233–238

1. Age (must be correct to score).
2. Time (to nearest hour).
3. Now give them an address for recall (3 items only—e.g. 98, Primrose Hill, Wimbledon—*repeated by the patient to ensure that it has been heard correctly*—don't score yet).
4. Year (must be correct).
5. Where are we?
6. Recognition of two people (usually the doctor and the carer).
7. Date of birth (they must give date, month, and year to score).
8. Year of world war (must be correct year of starting and stopping).
9. Name of present monarch.
10. Count backwards from 20 to 1 (each number from 20 back to 1 has to be in order—one missed number: no score).

Now ask them to recall the address given as point 3 above (2+ items recalled scores the point).

Scoring is one mark for each exactly correct. (Scoring is generally accepted as 6 or below as indicating probable dementia. However a score of 7 or 8 should be treated with caution and repeated.)

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The ‘SAD PERSONS’ scale and the Risk–Rescue Rating Scale

Table A3.1 The 'SAD PERSONS' scale

S	Sex is male
A	Age is older than 45 or younger than 19 years
D	Depression
P	Previous attempts
E	Ethanol abuse
R	Rational thinking loss (particularly psychosis)
S	Social support is lacking
O	Organized plan
N	No spouse
S	Sickness (physical illness, especially if painful)

Each positive item receives a score of 1. A flexible use of the following evaluation can be helpful:

- Score 0–2: Low risk. Discharge and outpatient follow-up.
- Score 3–4: Moderate risk. Close monitoring as outpatient. Consider admission.
- Score 5–6: High risk. Admission is advised, especially if support from environment seems uncertain.
- Score 7–10: Very high risk of suicide. Admission required.

From Patterson *et al* (1983). Evaluation of suicidal patients: the SAD PERSONS Scale. *Psychosomatics* **24(4)**:343–5, 348–9.

Table A3.2 The Risk–Rescue Rating Scale

Risk factors	**Rescue factors**
Agent used	*Location*
1. Ingestion, cutting, stabbing	3. Familiar
2. Drowning, asphyxiation, strangulation	2. Non-familiar, non-remote
3. Jumping, shooting	1. Remote
Impaired consciousness	*Person initiating rescue*[a]
1. None in evidence	3. Key person
2. Confusion, semi-coma	2. Professional
3. Coma, deep coma	1. Passer-by
Lesions/toxicity	*Probability of discovery by any rescuer*
1. Mild	3. High, almost certain
2. Moderate	2. Uncertain discovery
3. Seven	1. Accidental discovery
Reversibility	*Accessibility to rescue*
1. Good, complete recovery expected	3. Asks for help
2. Fair, recovery expected with time	2. Drops clues
3. Poor, residuals expected if recovery	1. Does not ask for help

Treatment required	*Delay until discovery*[b]
1. First aid. E. W. care	3. Immediate, 1 hour
2. Hospital admission, routine treatment	2. Less than 4 hours
3. Intensive care, special treatment	1. More than 4 hours
Total risk points =	**Total rescue points =**
Risk score	**Rescue score**
5 = High risk	1 = Least rescuable
(13–15 risk points)	(5–7 rescue points)
4 = High moderate	2 = Low moderate
(11–12 risk points)	(8–9 rescue points)
3 = Moderate	3 = Moderate
(9–10 risk points)	(10–11 rescue points)
2 = Low moderate	4 = High moderate
(7–8 risk points)	(12–13 rescue points)
1 = Low risk	5 = Most rescuable
(5–6 risk points)	(14–15 rescue points)

[a] Self-rescue automatically yields a rescue score of 5.
[b] If there is undue delay in obtaining treatment after discovery, reduce the final rescue score by one point.

This scale helps to assess the 'lethality' of a given parasuicide DSH case. It does so by estimating the ratio between risk of the behaviour and likelihood of rescue.

Risk–Rescue Score = A x 100/A+B, where **A** = risk score and **B** = rescue score. Thus the minimum risk–rescue score is 17 for a 'low lethality' self-harm behaviour. The maximum risk–rescue score is 83 for a 'high lethality' self harm case.

From Weissman and Worden (1972). Risk-rescue rating in suicide assessment. *Archives of General Psychiatry*. **26**:737–746.

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Antipsychotic drugs

Table A4.1 Antipsychotic drugs

Drug	Chemical group	Daily dose range (single daily dose unless stated)	Alternative licensed indications	Adverse effects (see data sheet for full details/Appendix 6 for comparison)	Interactions	Cost
Chlorpromazine	Phenothiazine (group I: aliphatic)	25–1000 mg	Anxiety, nausea, agitation, hiccough, induction of hypothermia, violence, autism	EPSE, anticholinergic, sedation, hypotension, hypothermia, endocrine disorders, convulsions, jaundice, ECG change, blood dyscrasias	Sedatives, lithium, anticholinergics, antiepileptics, sulfonylureas, cimetidine, antidepressants, dopamine (ant)agonists	+
Promazine	Phenothiazine (group I: aliphatic)	400–800 mg	Agitation and restlessness in elderly NB Weak antipsychotic	As chlorpromazine	As chlorpromazine	+
Fluphenazine	Phenothiazine (group III: piperazine)	1–20 mg	Agitation, anxiety, violence	As chlorpromazine + depression reported	As chlorpromazine	+
Perphenazine	Phenothiazine (group III: piperazine)	12–24 mg	Agitation, severe anxiety, violence	As chlorpromazine	As chlorpromazine	+

Trifluoperazine	Phenothiazine (group III: piperazine)	10–50 mg (estimated) (maximum dose not stated by manufacturers)	Agitation, severe anxiety, violence	As chlorpromazine	As chlorpromazine	+
Flupenthixol	Thioxanthine	6–18 mg	Depressive illness (low dose)	As chlorpromazine	As chlorpromazine	+
Zuclopenthixol	Thioxanthine	20–150 mg	None	As chlorpromazine	As chlorpromazine	+
Haloperidol	Butyrophenone	2.5–30 mg	Agitation, severe anxiety, violence, tics, nausea, hiccough, mania, Gilles de la Tourette syndrome	As chlorpromazine EPSE prominent	As chlorpromazine + fluoxetine, astemizole, terfenadine	+
Benperidol	Butyrophenone	0.25–1.5 mg (twice daily)	Deviant social/sexual behaviour NB Not licensed for schizophrenia and psychoses	As chlorpromazine	As chlorpromazine	++
Sulpiride	Substituted benzamide	400–2400 mg (twice daily)	None	As chlorpromazine Jaundice and skin reactions less common, galactorrhoea	As chlorpromazine	++

Table A4.1 Continued.

Drug	Chemical group	Daily dose range (single daily dose unless stated)	Alternative licensed indications	Adverse effects (see data sheet for full details/Appendix 6 for comparison)	Interactions	Cost
Loxapine	Dibenzoxazepine	20–250 mg (twice daily)	None	As chlorpromazine + nausea, dyspnoea, ptosis, polydipsia, paraesthesia Few endocrine effects reported	As chlorpromazine	++
Risperidone	Benzisoxazole	2–16 mg	None	As chlorpromazine + agitation, fatigue, anxiety, nausea, rhinitis, sexual dysfunction	As chlorpromazine	+++
Clozapine	Dibenzodiazepine	25–900 mg (twice daily)	None	As chlorpromazine + hypersalivation, delirium, incontinence, myocarditis, neutropenia, fatal agranulocytosis (see table)	As chlorpromazine + all drugs which depress leucopoiesis: (e.g. cytotoxic agents, sulphonamides, chloramphenicol, carbamazepine, phenothiazines) Fluoxetine and risperidone increase clozapine plasma levels	++++

Olanzapine	Thienobenzo-diazepine	5–20 mg	None	Sedation, weight gain, hypotension, anticholinergic effects, change in LFTs	Smoking and carbamazepine reduce olanzapine levels to small extent	++++
Quetiapine	Dibenzothiazepine	150–750 mg (twice daily) Lower doses in the elderly	None	Hypotension, sedation, dry mouth, constipation, weight gain, dizziness, changes in LFTs, TFTs	Caution with potent inhibitors of CYP3A4 (e.g. ketoconazole, nefazodone)	+++
Amisulpride	Substituted benzamide	Positive symptoms: 400–1200 mg (twice daily) Negative symptoms: 50–300 mg	None	Insomnia, agitation, anxiety, weight gain, hyperprolactinaemia, galactorrhoea	Few known interactions Caution with other sedatives, including alcohol, dopamine agonists Possibly hypotensive	+++
Ziprasidone	Benzothiazolyl-piperazine	40–160 mg (twice daily)	Not available in UK	Somnolence, nausea Rarely, dystonia, postural hypotension	Few known interactions Does not inhibit cytochrome enzymes Ziprasidone levels slightly decreased by carbamazepine and increased by cimetidine	+++
Aripriprazole	Partial dopamine agonist	5–30 mg (twice daily)	None	Agitation		+++

EPSE, extrapyramidal effects; LFT, liver function test; TFT, thyroid function test.

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Antipsychotic depot injections: suggested doses and frequencies

Typical antipsychotics

Drug	Trade name	Test dose (mg)	Dose range (mg/week)	Dosing interval (weeks)	Comments
Flupenthixol decanoate	Depixol	20	12.5–400	2–4	Mood elevating; may worsen agitation
Fluphenazine decanoate	Modecate	12.5	6.25–50	2–5	Avoid in depression, high EPSE
Haloperidol decanoate	Haldol	25[a]	12.5–75	4	High EPSE, low incidence of sedation
Pipothiazine palmitate	Piportil	25	12.5–50	4	Lower incidence of EPSE
Zuclopenthixol decanoate	Clopixol	100	100–600	2–4	Useful in agitation and aggression

EPSE, extrapyramidal side effects.
[a] Test dose not stated by manufacturer.

Notes
- Give a quarter or half stated doses in elderly.
- After test dose, wait 4–10 days before starting titration to maintenance therapy.
- Dose range is given in mg/week for convenience only; avoid using shorter dose intervals than those recommended except in exceptional circumstances (e.g. long interval necessitates high-volume (>3–4ml) injection).

Atypical antipsychotics

Drug	Trade name	Test dose (mg)	Dose range (mg/week)	Dosing interval (weeks)	Comments
Risperidone long-acting injection	Risperdal Consta	Not required	12.5–25	2	Lower incidence of EPSE

Notes
- 25–50 mg every 2 weeks of risperidone long-acting injection (RLAI) appears to be as effective as oral doses of 2–6 mg/day.
- Prior testing of tolerability with oral risperidone is desirable but not always practical.
- RLAI takes 3–4 weeks for the first injection to reach therapeutic plasma levels.
- Switch from oral: full-dose oral supplementation is required for first 3 weeks (minimum).
- Switch from typical depot: give first injection of RLAI a week before the last depot or on the depot due date.

Equivalent doses, maximum daily doses, and adverse effects of antipsychotics

Equivalent doses of typical antipsychotics

Drug	Equivalent dose (consensus)	Range of values in literature (mg/day)
Chlorpromazine	100 mg/day	–
Fluphenazine	2 mg/day	2–5 mg/day
Trifluoperazine	5 mg/day	2.5–5 mg/day
Flupenthixol	3 mg/day	2–3 mg/day
Zuclopenthixol	25 mg/day	25–60 mg/day
Haloperidol	3 mg/day	1.5–5 mg/day
Sulpiride	200 mg/day	200–270 mg/day
Loxapine	10 mg/day	10–25 mg/day
Fluphenazine depot	5 mg/week	1–12.5 mg/week
Pipothiazine depot	10 mg/week	10–12.5 mg/week
Flupenthixol depot	10 mg/week	10–20 mg/week
Zuclopenthixol depot	100 mg/week	40–100 mg/week
Haloperidol depot	15 mg/week	5–25 mg/week

All values should be regarded as approximate.
No equivalent doses are given for atypical antipsychotics because their more variable D2 occupancy makes this illogical.

Oral/parenteral dose equivalents

Drug	Oral dose (mg)	Equivalent i.m. or i.v. dose (mg)
Benzodiazepines		
Diazepam	10	10
Lorazepam	4	4
Antipsychotics		
Chlorpromazine	100	25–50
Haloperidol	10	5
Promazine	200	200
Anticholinergics		
Procyclidine	10	7.5

Note
Because of the variation in bioavailability with some drugs, prescriptions should always specify the dose *and* a single route of administration.

Maximum daily doses of antipsychotics

Drug	Licensed maximum dose
Chlorpromazine	1000 mg/day
Fluphenazine	20 mg/day
Trifluoperazine	None
Flupenthixol	18 mg/day
Zuclopenthixol	150 mg/day
Haloperidol	30 mg/day
Sulpiride	2400 mg/day
Loxapine	250 mg/day
Clozapine	900 mg/day
Risperidone	16 mg/day
Fluphenazine depot	50 mg/week
Pipothiazine depot	50 mg/week
Haloperidol depot	300 mg every 4 weeks
Flupenthixol depot	400 mg/week
Zuclopenthixol depot	600 mg/week
Amisulpride	1200 mg/day
Olanzapine	20 mg/day
Zotepine	300 mg/day
Ziprasidone	160 mg/day
Quetiapine	750–800 mg/day
Aripiprazole	30 mg/day

Note

Doses above these maxima should only be used in extreme circumstances; there is no evidence for improved efficacy. Always follow Royal College of Psychiatrists guidelines.

Relative adverse effects of antipsychotics

Drug	Sedation	Extrapyrimidal	Anticholinergic	Hypotension	Prolactin elevation
Chlorpromazine	+++	++	++	+++	+++
Promazine	+++	+	++	++	++
Fluphenazine	+	+++	++	+	+++
Perphenazine	+	+++	+	+	+++
Trifluoperazine	+	+++	+/–	+	+++
Flupenthixol	+	++	++	+	+++
Zuclopenthixol	++	++	++	+	+++
Haloperidol	+	+++	+	+	+++
Benperidol	+	+++	+	+	+++
Sulpiride	–	+	–	–	+++
Loxapine	++	+++	+	++	+++
Clozapine	+++	–	+++	+++	–
Risperidone[a]	+	+	+	++	+++
Olanzapine	++	+/–	+	+	+
Quetiapine	++	–	+	++	–
Amisulpride	–	+	–	–	+++
Zotepine	+++	+	+	++	+++
Ziprasidone	+	+/–	–	+	+/–
Aripirazole	–	+/–	–	–	–

+++ High incidence/severity; ++ moderate; +, low; -, very low/none.
[a] Akathisia common with risperidone.

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Clozapine: management of adverse effects

Table A7.1 Clozapine: management of adverse effects

Adverse effect	Time course	Action
Sedation	First 4 weeks. May persist. but usually wears off	Give smaller dose in the mornings. Some patients can only cope with single night-time dosing. Reduce dose if necessary
Hypersalivation	First 4 weeks. May persist, but usually wears off. Often very troublesome at night	Give hyoscine 300 µg (Kwells) chewed and swallowed at night. Propantheline 15 mg tds may be used but worsens anticholinergic effects. Pirenzepine may be tried. Patients do not always mind excess salivation–treatment not always required
Constipation	Usually persists	Recommend high-fibre diet. Bulk-forming laxatives ± stimulants may be used
Hypotension	First 4 weeks	Advise patient to take time when standing up. Reduce dose or slow down rate of increase. If severe, consider moclobemide and Bovril
Tachycardia	First 4 weeks, but often persists	Often occurs if dose escalation is too rapid. Inform patient that it is not dangerous. Give small dose of beta-blocker if necessary
Weight gain	Usually during the first year of treatment	Dietary counselling is essential. Advice may be more effective if given before weight gain occurs. Weight gain is common and often profound (>2 stones)
Fever	First 3 weeks	Give antipyretic. NB: This fever is not usually related to blood dyscrasias
Seizures	May occur at any time	Dose related. Consider prophylactic valproate[a] if on high dose. After a seizure withhold clozapine for 1 day. Restart at reduced dose. Give sodium valproate
Nausea	First 6 weeks	May give antiemetic. Avoid prochlorperazine and metoclopramide (EPSE)
Neutropenia/ agranulocytosis	First 18 weeks (but may occur at any time)	Stop clozapine; admit to hospital
Nocturnal enuresis	May occur at any time	Try manipulating dose schedule. Avoid fluids before bedtime. In severe cases, desmopressin is usually effective.

[a] Usual dose is 1000–2000 mg/day. Plasma levels may be useful as a rough guide to dosing — aim for 50–100 mg/L. Use of modified-release preparation (Epilim Chrono) may aid compliance: can be given once daily and may be better tolerated.

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